Nuffield Health Newcastle-upon-Tyne Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health Newcastle upon Tyne Hospital was inspected as part of our planned inspection programme. This was a comprehensive inspection and we looked at the two core services provided by the hospital: surgery, outpatients and diagnostic imaging. The announced inspection was carried out on 24 and 25 May 2016 and an unannounced inspection on 7 June 2016.

The hospital contracted services for MRI and CT scanning and these services did not form part of this inspection report.

The Nuffield Health Newcastle upon Tyne Hospital was rated as good overall for being safe, effective, caring, responsive and well led.

Are services safe at this hospital/service

Overall we rated safe as good because:

- Incidents, accidents and near misses were recorded and investigated appropriately. Incidents were discussed during departmental meetings and at handover, so shared learning could take place. There was a Being Open and Duty of Candour policy. Staff were familiar with the process for Duty of Candour. We reviewed two Root Cause Analysis incident investigation reports, which showed Duty of Candour and explained the care and delivery problems, contributory factors and lessons learned.
- Risk assessments were completed at each stage of the patient journey from admission to discharge, with an early warning scoring system used for the management of deteriorating patients. The Five Steps to Safer Surgery checklist was completed and monitored appropriately. There was a clear procedure in the event of a major haemorrhage and obtaining blood components in such an emergency.
- The services reported no safeguarding concerns during 2015. The hospital matron was the designated lead for safeguarding and had completed level three safeguarding training. Staff were aware of their roles and responsibilities for safeguarding and could describe what types of concerns they would report and the system for doing so.
- There were processes to ensure safe nurse staffing levels. The hospital followed national staffing guidance such as the National Quality Board 2013 as a basis to provide safe and efficient rotas. All departments were appropriately staffed. Staff were flexible in working patterns to meet the needs of the service and patient requests. Staff turnover and sickness rates were low.
- Two resident medical officers (RMO) on duty were advanced life support trained and available for assistance 24 hours a day seven days a week. All patients were admitted under a named consultant who had clinical responsibility for their patient during their entire stay. There was a named anaesthetist responsible for the patient along with their named surgeon. However, it was identified that some anaesthetists left the recovery area before they should and although the patient was awake and well, they did not wait until the patient left recovery, which was not best practice.

Are services effective at this hospital/service

Overall we rated effective as good because:

- Patients received care and treatment in line with national guidelines such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. The hospital participated in national audit programmes including performance related outcome measures (PROMS) and the National Joint Registry. Results showed patient outcomes were within expected levels when compared to national averages.
- The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to other independent hospitals.

Summary of findings

- Patients were consented in line with Department of Health and hospital policy guidelines. There were systems to ensure a 'cooling off' period of two weeks for patients undergoing cosmetic surgery. Staff had received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. There was access to an Independent Mental Capacity Advocate when best interest decisions were required.
- The Medical Advisory Committee (MAC) monitored compliance with practicing privileges and there was evidence of action taken by the MAC and executive director when competence issues arose.

Are services caring at this hospital/service

Overall we rated caring as good because:

- We observed patients being treated with compassion, dignity and respect throughout our inspection. Staff were courteous and helpful in all roles. All staff we met during inspection were approachable and friendly.
- All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- Results from the Friends and Family test showed 99% of patients attending for surgery were happy with the service they had received. 100% of patients attending outpatients would be extremely likely to recommend the service to friends and family.
- The in-patient led assessments of the care environment (PLACE) scores showed 98% for privacy and dignity.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. All nurses were trained in counselling. Patients receiving cosmetic, bariatric or breast cancer treatment could receive support from a psychologist.

Are services responsive at this hospital/service

Overall we rated responsive as good because:

- There were effective arrangements for planning and booking of surgical activity through contractual agreements with clinical commissioning groups. Private patients did not receive priority over NHS patients and staff confirmed there was no difference in the way staff treated patients.
- Patients admitted to Nuffield Health Newcastle were assessed for admission suitability by their consultant using selected risk criteria in line with local and national guidelines. This meant that the majority of patients treated at the hospital were considered as 'low risk'. There was a service level agreement with the local NHS hospital trust for the urgent transfer of patients who required a higher level of care.
- The hospital had four dementia champions. The hospital dementia rating in the PLACE audit was slightly lower than the England average (77% compared to 81%). This was due to some shortfalls in dementia friendly environmental indicators such as signage and flooring. The hospital were reviewing these findings to see what reasonable adjustments could be made to the environment to improve care for these patients. Staff were trained in dementia care and in the use of 'This is me' documentation for patients with learning disabilities.
- The hospital was consistently better than the national referral to treatment (RTT) waiting time target of 92% for incomplete admitted patients beginning treatment within 18 weeks of referral throughout 2015.
- In 2015, the turnaround time audit in diagnostic imaging confirmed 97% of all diagnostic imaging was reported within the five-day benchmark.
- Pathology services recorded performance and turnaround times against Nuffield benchmarking and national accreditation standards. In March 2016, routine turnaround times for selected pathology tests performed in the hospital showed 98% and 93% for standard biochemistry and haematology specimens accordingly. Overall, the hospital reported 94% compliance on turnaround times for all selected tests.

Summary of findings

- The senior management team (SMT) discussed complaints on a weekly basis. Information was shared through the clinical heads of department, integrated governance and MAC meetings. Heads of department provided feedback to staff on outcomes and lessons learned from complaints. Unresolved complaints for private patients were past to the Independent Sector Complaints Adjudication Service (ICAS) or Parliamentary Health Service Ombudsmen for NHS patients. There were no complaints received since December 2015.

Are services well-led at this hospital/service

Overall we rated well-led as good because:

- There was a clear vision and strategy for the hospital, which staff understood.
- The hospital had an integrated governance framework to support the delivery of clinical excellence and patient satisfaction. We reviewed hospital board, heads of department, MAC and governance group minutes. All considered key governance factors such as safety, quality, performance and finances.
- There were various assurance systems and service measures to monitor compliance and performance. The hospital produced monthly quality and safety dashboard data. These included indicators covering safety thermometer variables, readmission rates, patient satisfaction data and departmental key performance indicators.
- The hospital manager through the MAC and human resources ensured any consultant seeking practising privileges had appropriate and valid professional indemnity insurance in accordance with the Indemnity Arrangements Order 2014. We looked at three files for the most recent consultant appointments all appropriate checks were in place.
- The hospital requested sight of relevant appraisal documentation from the consultant's main employing organisation about performance against national standards. The hospital completed its own internal appraisal for sharing with the primary NHS trust appraiser. However, the information flow between the hospital and NHS trust particularly around scope of practice was currently based on a consultant's self-declaration rather than a formal process and this area could be strengthened.
- The roles and responsibilities of the MAC were well defined and there was good engagement in governance oversight, particularly around reviewing practising privileges and advising on consultant performance.
- The hospital was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role. We looked at three employment files, which were completed in line with the FPPR regulations. All relevant pre-employment checks were evident such as identification, written references (and verbal in one case), checking of qualifications (Association of Chartered Certified Accountants for finance, Nursing and Midwifery Council, Disclosure and Barring Service and Occupational Health clearance).
- Staff were confident that leaders had the skills, knowledge, experience and integrity that they needed to manage the organisation. This included skills such as capacity, capability, and experience to lead effectively. There was an open and honest culture, which was reinforced through the hospitals' values and behaviours.
- There were processes to monitor quality and sustainability. Although there were key financial targets to meet there was no evidence that this affected patient safety.

Our key findings were as follows:

- There were processes for the effective control and prevention of infection. There were no hospital-acquired infections during 2014/2015. All areas were visibly clean. There was however a lack of storage facilities in theatres and some wards. Staff on the ward showed us their concerns about the lack of storage. Storage cupboards were organised and tidy but full to capacity.
- Medical and nurse staffing levels were adequate on the ward, theatres, outpatients and diagnostic services. Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.
- There were no expected or unexpected deaths during 2014/2015.
- Records were well maintained and documents were completed to a good standard including completion of patient risk assessments.

Summary of findings

- Staff understood their responsibilities to raise concerns and record patient safety incidents and near misses. There was evidence of a culture of learning and service improvement.
- Processes were in place to ensure patients nutrition and hydration was effectively managed prior to and following surgery. Access to dietician input was available.
- There was sufficient equipment to ensure staff could carry out their duties. There were systems for monitoring and maintaining equipment.
- Patients were treated with respect, dignity and compassion. Patients described positive experiences at the hospital.
- There were systems for the effective management of staff, which included an annual appraisal. All doctors were appropriately assessed to ensure they had the skills to undertake surgical procedures. There were no whistleblowing concerns.
- Clinic appointment times were managed around patient need. Waiting times and reporting of diagnostic and pathology requests met the required national standards.
- Senior and departmental leadership at the hospital was good. Leaders were aware of their responsibilities to promote patient and staff safety and wellbeing. Leaders were visible and there was a culture, which encouraged candour, openness and honesty.
- Integrated governance arrangements enabled the effective identification and monitoring of risks and action was taken to improve performance. Progress on achieving improvements were reported and measured through the relevant management committees with oversight and scrutiny from the provider's quality governance committees with ultimate responsibility resting with the group chief executive and board.

We saw several areas of outstanding practice including:

- At pre-assessment, the provider had access to information held by community services, including GPs. GPs were asked for faxed summary sheets which provided the hospital with details of the patient's medical history and medications. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicines.
- The development of breast services to include areola micropigmentation had brought about positive outcomes for patients. Local referrers recognised this and the service had been extended to reduce NHS waiting times.
- In oncology outpatients, the lead nurse adapted a regional network policy for the benefit of patients receiving chemotherapy who may require telephone advice and triage (assessment of clinical need) out-of-hours.
- Departmental initiatives to support children attending outpatients or diagnostic imaging were innovative with infection prevention education and try at home 'role-play' exercises to reduce anxiety and distress.
- The hospital worked closely with the local Jehovah witness hospital liaison group, who provided staff training, information leaflets such as what to do prior to surgery and alternatives to blood transfusion.

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

The provider should:

- Ensure that processes for evidencing changes to a consultant's scope of practice are strengthened between the independent hospital and NHS trust rather than solely relying on a clinician's self-declaration.
- Ensure that staff follow best practice guidance post operatively (for example, anaesthetists to wait until a patient leaves the recovery area even though the patient maybe awake and well).
- Continue to address the storage issues in theatres and on some wards.
- Continue to improve the environment where reasonable to ensure it is appropriate for patients with dementia.
- Review the room risk assessments in radiology, which were generic and lacked specific detail.
- Local written procedures in radiology should clarify what annotation is required by operators and practitioners to satisfy correct safety checks have been made.

Summary of findings

- The hospital should ensure there is a robust x-ray equipment capital replacement plan to ensure future reliability and quality.
- Ensure a clinical record of every attendance is kept in a patient record on site.
- Consider the provision of a disabled access toilet in diagnostic imaging.
- Consider putting a formal process in place to support those patients with learning difficulties or special needs.
- Revisit the patient journey in outpatients regarding confidentiality at reception desks, conflicting signage in outpatients and the Jesmond Clinic.
- Progress refurbishment plans for the replacement of material covered chairs to alternatives, which can be easily cleaned.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated surgical services as good because: Staff knew the process for reporting and investigating incidents. They received feedback from reported incidents and felt supported by managers when considering lessons learned. Wards used an early warning scoring system for the management of deteriorating patients and risk assessments were completed appropriately. There were systems to ensure effective infection prevention and control. All areas were clean. Staff were aware of safeguarding policies and procedures and had received training. Staff treated patients with compassion, dignity, and respect. Patients could access counselling from nurses and psychological support if necessary. Staffing levels and skill mix were appropriate. There was good multi-disciplinary working and staff had the skills and competences to meet patient needs. There were processes to ensure the quality of patient care was monitored and learning was shared with staff. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. However There were storage problems in theatre and on somethe wards. Theatre storage issues caused clutter and blocked a fire exit. Storage problems had been recorded on the risk register and hospital business plan, in April 2016 and two additional cupboards for storage hads been sourced around the hospital. A quote had previously been sought for shelving and racking in theatre. Some actions had been taken, and the hospital recognised there was much additional work to be done. Anaesthetists were available post-operatively. However, it was identified that some left before they should and although the patient was awake and well, they did not wait until the patient left the recovery area, which was not best practice.

Summary of findings

Outpatients and diagnostic imaging

Good

We rated outpatient and diagnostic imaging as good because:
Staff were confident in reporting and investigating incidents using the hospitals reporting system. Staff received feedback from reported incidents, lessons learnt were cascaded and positive changes to practice followed.
Compliance with internal safety measures such as infection prevention and control audits and mandatory training met the hospitals targets.
Staff were flexible in their working patterns to support the needs of the service and patient requests.
Patient care followed evidence-based practice, national guidelines and best practice standards.
Skilled and competent staff delivered care.
Staff interactions were kind, compassionate and genuine. Patients acknowledged the quality of the care they received.
Service planning and development was patient focussed with efficient turnaround times for investigation results allowing care to proceed immediately. Waiting times met national standards.
Departments had good governance and risk strategies with compliance against radiation legislation particularly robust.
Local and senior managers within the hospital were visible, supportive and approachable.
However:
Some reception areas were not conducive to private conversations, which could inadvertently lead to breaches in confidentiality or data protection.
Patients were sometimes confused by the signage and branding situated in the second floor outpatient department, which combined as 'The Jesmond Clinic' providing cosmetic and weight loss services.
Clinic waiting times were not displayed and the process of informing patients of real or potential delays was variable.
Some room risk assessments in radiology were generic and lacked specific detail.

Summary of findings

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Good

Nuffield Health Newcastle upon Tyne Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Newcastle-upon-Tyne Hospital

The Nuffield Health Newcastle upon Tyne Hospital was founded in 1973. It is part of Nuffield Health a not for profit organisation.

The hospital underwent a £7 million refurbishment in 2008. There are three theatres, 27 private en-suite bedrooms, 8 bed day case suite and 18 consulting rooms with dedicated ENT, ophthalmology and gynaecology rooms.

The registered manager had recently left and an interim manager who was the hospital director was covering the site until a permanent appointment was in place. An application to add Newcastle upon Tyne registration for a new manager was submitted to CQC on 22 April 2016. The interim hospital director was also the Controlled Drugs Accountable Officer: registration had been submitted to CQC and was waiting for confirmation.

The hospital was inspected as part of our planned inspection programme. This was a comprehensive inspection and we looked at the two core services provided by the hospital: surgery, outpatients and diagnostic imaging.

Our inspection team

Our inspection team was led by:

Inspection Lead: Helena Lelew, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: an independent healthcare hospital director, a surgeon with independent healthcare surgical experience, a surgical nurse and a senior radiographer.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. We carried out an announced inspection visit on 24 and 25 May 2016 and an unannounced inspection on 7 June 2016. We spoke with patients and staff from the ward, operating department, radiology, physiotherapy and outpatient services. We observed how patients were being cared for and reviewed patients' records of personal care and treatment.

Information about Nuffield Health Newcastle-upon-Tyne Hospital

Nuffield Health Newcastle Hospital serves the population of the North East and surrounding areas. The hospital receives referrals predominately from Newcastle Gateshead CCG, Northumberland CCG and North Tyneside CCG, plus a small amount from other locations. There is a service level agreement in place with the Newcastle upon Tyne Hospitals NHS Trust for the urgent transfer of patients who require a higher level of care.

The hospital offered a range of services to NHS and other funded (insured and self-pay) patients including

Summary of this inspection

orthopaedics, general and vascular surgery, cosmetic surgery, ear, nose and throat, oncology, gynaecology, ophthalmology and urology. The hospital did not admit emergency patients. Following a review of children's inpatient services, the hospital no longer provided this care however referrals for outpatient care and non-interventional diagnostic services were still accepted.

The hospital contracted services for MRI / CT scanning. Pathology was provided, as part of Nuffield Health Pathology was a hub and spoke system covering all Nuffield Hospitals and external clients. The department had a spoke site at Nuffield Tees in Stockton where a specimen reception was located with limited point of care testing facilities. Other outsourced services included laundry, facilities, catering and medical device maintenance.

Between January and December 2015 data showed:

- Inpatient activity was 5,173 of which 1,697 patients were NHS funded.
- Outpatient activity was 24,990. NHS funded patients accounted for 3,395 of these attendances and 21,595 were classified as 'other funded'.
- There were 6,244 visits to the theatre.
- The five most common surgical procedures performed were: total knee replacement (415), knee arthroscopy (360), total hip replacement (327), diagnostic colonoscopy (313), diagnostic gastroscopy (236).
- 2,099 overnight inpatient stays
- 4,635 day cases
- There were seven surgical site infections
- There were no incidences of MRSA, C. difficile or MSSA between January 2015 and December 2015.
- There were no expected or unexpected deaths
- There were no never events, (these are serious incidents that are wholly preventable).
- Referral to Treatment Times (RTT) within 18 weeks (target 90%) showed that Nuffield Health Newcastle consistently met standards for admitted NHS patients in 2015.
- Venous Thromboembolism (VTE) screening rates in each quarter of the reporting period was 100% (against a 95% target rate of screening for NHS contracts).
- Eleven cases of unplanned transfer of an inpatient to another hospital. The rate of unplanned transfers (per 100 inpatient discharges) had fallen over the same period.
- There were three cases of unplanned readmissions within 29 days of discharge to another hospital. The rate of unplanned readmissions (per 100 inpatient discharges) had fallen in the same reporting period.
- There was one unplanned return to the operating theatre.
- There were 231 doctors working under the rules of practicing privileges and 2 employed doctors. 41.6 whole time equivalent (WTE) nurses, 3.8 WTE operating department practitioners, 12.7 WTE care assistants and 76.8 WTE other hospital staff.
- The patient-led assessment of the care environment (PLACE) showed the hospital better than the England average for cleanliness (100% England average 98%), food (98% England average 93%) privacy, dignity and well-being (93% England average 87%), environment (96% England average 92%) and worse than the England average for dementia (77% England average 81%).
- Between July and December 2015, the number of patients who would recommend the hospital to their friends and family was better than the England average of 85%.
- There were 31 complaints during 2015.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We are will rate effectiveness where we have sufficient, robust information, which answer the KLOE's and reflect the prompts.

Good

Surgery

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

Information about the service

Nuffield Health Newcastle upon Tyne Hospital was founded in 1973. In 1984, the hospital doubled in size following a significant extension into an adjacent area creating the South Wing of the existing hospital. During 2008, the hospital underwent large-scale refurbishment, updating theatres, wards, out patients, general offices and public areas. The hospital is situated in Jesmond, a suburb of Newcastle upon Tyne, with good public transport links.

Nuffield Health Newcastle had local service agreements in place with local trusts to provide services for NHS patients. Other patients seen at Nuffield Health were private and insured patients.

The hospital provided a range of surgical services including cosmetic and general, orthopaedic and urology surgery. There were 6244 visits to theatre between January 2015 and December 2015 of which 1697 were NHS funded patients. The five most common surgical procedures performed were total knee replacement (415), knee arthroscopy (360), total hip replacement (327), diagnostic colonoscopy (313) and diagnostic gastroscopy (236). There were no waiting times for theatre. There were 27 overnight beds and eight-day case beds.

We spoke with 11 patients and 10 members of staff. We visited all wards and theatres. We observed care and treatment and looked at 10 care records.

Previous inspection findings showed there were no areas of non-compliance found in this core service.

Summary of findings

We rated surgical services as good because:

- Staff knew the process for reporting and investigating incidents using the hospitals reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- Wards used an early warning scoring system for the management of deteriorating patients. A number of other relevant risk assessments were used for example the prevention of venous thromboembolism (VTE), falls prevention, and promotion of skin integrity. Infection prevention and control information was visible in all ward and patient areas. All areas were clean.
- We saw staff treating patients with compassion, dignity, and respect throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them. We saw patient information leaflets explaining procedures and after care arrangements. Patients could access counselling from nurses and psychological support if necessary.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. All the staff we spoke with were aware of the safeguarding policies and procedures and had received training.
- All wards and theatres had an appropriate skill mix during shifts. Generally, staff ratio was one to five and increased to one to four when needed. We reviewed

Good

Surgery

the nurse staffing levels on all wards and within theatres and found that staffing levels and skill mix were appropriate. The hospital had an escalation policy and procedure to deal with busy times.

- Staff treated patients in line with national and local clinical guidelines. Records for 2015 showed that 100% of staff across wards, surgery, and theatres received an appraisal. There was good multidisciplinary team working. Complaints were managed in line with hospital policy and learning from complaints was identified.
- The department held clinical governance and ward meetings each month. We saw that the risk register was updated following these meetings and action plans were monitored across the hospital. Staff said managers were available, visible, and approachable; leadership of the service was good, there was good staff morale and staff felt supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.

However:

- We found the storing of theatre logs to be inappropriate. Logs were archived in a storage cupboard, which was not locked or secure at the time of inspection. The storage area also contained other items such as general storage. We raised the concern during the inspection and the door was secured immediately.
- We saw difficulties with storage on site. There was a lack of storage in theatre and on the wards. Theatre storage issues caused clutter and blocked a fire exit. Staff stated they were constantly moving supplies to free space. Storage problems had been recorded on the risk register.

Are surgery services safe?

Good

We rated safe as good because:

- Staff were familiar with the process for reporting and investigating incidents using the hospital's electronic reporting system and feedback was given from a senior level. Records showed risk assessments were completed at each stage of the patient journey from admission to discharge, with an early warning scoring system used for the management of deteriorating patients. We observed theatre staff practice the 'Five Steps to Safer Surgery and complete the World Health Organisation (WHO) checklist appropriately.
- All staff we spoke with were aware of safeguarding policies and procedures and had received training. There was effective management of infection prevention and control and medicines.
- Planned staffing levels for wards worked to a one to five ratio. In times of greater patient need, ward staff ratios increased to one to four and one to one if a patient had delirium or dementia. We reviewed the nurse staffing levels on all wards and within theatres and found that staffing levels and skill mix were appropriate.
- The hospital had an escalation policy and procedure to deal with busy times and bed management meetings were held to monitor bed availability on a daily basis. Surgical consultants from all specialities were involved in handovers. There were arrangements to manage major incidents.

However:

- We found the storing of theatre logs to be inappropriate. Logs were archived in a storage cupboard, which was not locked or secure at the time of inspection. The storage area also contained other items such as general storage. We raised the concern during the inspection and the door was secured immediately.
- We saw difficulties with storage on site. There was a lack of storage in theatre and on the wards. Theatre storage issues caused clutter and blocked a fire exit. Staff stated they were constantly moving supplies to free space. Storage problems had been recorded on the risk register and hospital business plan in April 2016 and two additional cupboards for storage has been sourced

around the hospital. A quote had previously been sought for shelving and racking in theatre. Some actions had been taken, and the hospital recognised there was additional work to be done.
- Anaesthetists were available post-operatively. However, it was identified that some left before they should and although the patient was awake and well, they did not wait until the patient left the recovery area, which was not best practice.

Incidents

- There had been no never events between January 2015 and December 2015. Never Events are serious incidents that are wholly preventable.
- There were 285 clinical incidents reported between January 2015 and December 2015. Incidents showed trends around medicine management, due to high numbers of new staff. Nuffield Health tried different approaches and introduced a management form, which had shown improvement in this area during 2016.
- Senior staff stated that all staff were aware of their responsibilities and knew how to use the electronic incident reporting system to record and grade the severity of an incident. Staff raised concerns with their manager and a decision was made together regarding the severity of the incident to be recorded. All incidents reported were discussed monthly at the department meeting.
- We heard evidence and examples of lessons learned. We were advised that changes were made to systems to prevent wrong site nerve block procedures in 2014. Concerns had been discussed at the Medical Advisory Committee (MAC). New processes included a form, which was completed by the bookings team to ensure the appropriate information was gathered, followed by marked surgical sites, which had a verbal check as well as an observational check. There had been instances when the wrong site had been completed on the consent form so an anaesthetist also took responsibility to check this.
- The hospital confirmed they did not have any Regulation 28 reports issued in the past 12 months. A Regulation 28 is a report issued by a coroner where the coroner believes that action is required to prevent future deaths.
- Morbidity and mortality was discussed at monthly governance meetings as and when required. The senior management team attended these meetings. There were no expected or unexpected deaths in the reporting period (January 2015 to December 2015).
- There were no serious injuries reported to the Care quality Commission (CQC) since January 2015.
- No Statutory Notifications were made to CQC between January 2015 to December 2015.
- Staff were familiar with the process for Duty of Candour. Senior management explained that patients were advised verbally when an incident had occurred and following investigation, patients were informed of cause, outcome and given an apology in writing. We reviewed two Root Cause Analysis (RCA) incident investigations, which showed Duty of Candour and explained care and delivery problems, contributory factors, root causes and lessons learned. The reports were of good quality, detailed and completed within the required timescales. We saw letters of apology and explanations sent to patients, which were empathic and comprehensive.

Safety thermometer or equivalent

- There were no catheter urinary tract infections; two new venous thromboembolisms (VTE) and no pressure ulcers reported from January 2015 to December 2015.
- The VTE screening rate in each quarter was 100% from January to December 2015 (against a 95% target rate of screening for NHS contracts).
- Slips, trips and falls assessment completion rates were 85% which was below target. We saw actions plans were in place to increase assessments.

Cleanliness, infection control and hygiene

- All NHS patients were screened for Methicillin Resistant Staphylococcus Aureus (MRSA), (contractual) with all other patients screened on a risk based approach. For instance, all patients having implants were screened and anyone answering 'yes' to the risk assessment completed as part of the care pathway. There were two options to treatment depending on the nature of the surgery: the patient was either given treatment for 5 days (with day 5 being the day of surgery) or they received 5 days of treatment followed by three clear swabs before surgery. Compliance rates were 100%.

Good

Surgery

- There had been no incidences of MRSA, Meticillin Sensitive Staphylococcus Aureus (MSSA) or Clostridium Difficile (C.Diff) reported between January 2015 and December 2015 in surgery.
- There was one surgical site infection (SSI) for knee surgery; two SSI's for other limb surgery, two SSI's reported for abdominal surgery and two thoracic surgery between January 2015 and December 2015.
- There were appropriate sterilisation and disinfection processes. For example, there were separate rooms for the cleaning, usage and disposal of clean and dirty equipment.
- Nuffield Health had a Director of Infection, Prevention and Control (DIPC), an IPC lead nurse and IPC link nurses for the hospital who had received specialist training.
- All staff had IPC and asepsis competency training provided by the IPC nurse, which included hand hygiene.
- Hand hygiene audits for December 2015 showed 80% compliance rate.
- The inpatient led assessments of the care environment (PLACE) showed scores of 100% in cleanliness.
- Ward managers were aware of the local microbiology protocols for the administration of antibiotics and told us they would liaise with pharmacy prior to prescribing for MRSA and C.Diff.
- We saw numerous hand washing areas in corridors and each patients bathroom. There were hand gel facilities on the wards and we observed staff follow hand hygiene procedures and 'Bare below the Elbow' guidance appropriately.
- Nuffield Newcastle reported details of health care associated infections on a monthly basis. Audits showed that there were two externally reportable infections of E.coli between January 2015 and December 2015. There were no other infections to report.
- All equipment we observed was clean and toilet seats had 'I am clean' stickers.
- Legionella risk assessments were completed in line with the Approved Code of Practice L8.
- IPC audits included surgical wound monitoring and monitoring of peripheral lines and cannulas, which showed 100% compliance rates.
- There was a cleaning audit tool for each area. Audits for July 2016 showed areas meeting over 90% targets. Each head of department and housekeeping manager carried out the audit of cleanliness on an agreed weekly or daily schedule as requested by the IPC Committee.

Environment and equipment

- The building design, maintenance, and use of equipment was appropriate. However, we saw difficulties with storage on site. Although tidy, storage areas were full to capacity making stock rotation difficult.
- There was a lack of storage in theatre and on the wards. Theatre storage issues caused clutter and blocked a fire exit. Staff stated they were constantly moving supplies to free space. We raised concern at the time of inspection and the fire exits were cleared.
- We saw good arrangements for managing waste and clinical specimens.
- All electrical equipment had undergone a safety test and were up to date.
- We saw personal protective equipment (gloves, aprons and wipes) was available in sluice / storage areas as well as in individual patient rooms.
- A medical devices team managed the loan equipment. If there were problems with decontamination, the kit was returned straight away. Records of this were kept in theatre.
- There was a traceability process for theatre surgical trays. All were tracked and could be traced using med-track forms.
- We found bariatric surgery was carried out with safe and appropriate equipment for the patient group.
- The maintenance team responded seven days per week to fix broken or defective equipment.
- We observed an open fire door with signage that stated it must be kept locked.
- Instruments, equipment and implants complied with Medicines and Health Care Products (MHRA) requirements. There were processes for providing feedback on product failure to the appropriate regulatory authority through the Medical Advisory Committee (MAC).
- All facilities, surgical and anaesthetic equipment including resuscitation and anaesthetic equipment was available, fit for purpose and checked in line with guidance.

- Nuffield Health Hospitals Sterile Services Unit (HSSU) was a division of Nuffield Health offering a bespoke decontamination service for re-useable medical devices (surgical instruments). We were informed that there were several HSSU incidents at the beginning of 2015. There were three transportation and deliveries of kit each day and previously a number of problems relating to decontamination, such as broken seals. Senior management and the HSSU co-ordinator worked together to resolve issues and the situation had now improved with less incidents occurring.
- PLACE scores for environment and facilities was 95.6%

Medicines

- We found allergies were clearly recorded on the prescribing document. We checked 10 records at random and found these to be correctly completed.
- All medicines were prescribed and administered in line with the hospital policy and procedures. The pharmacist liaised with the ward team regularly and held monthly medicine management meetings.
- Controlled Drugs (CD) checking took place as per hospital policy. The pharmacy department performed a two person quarterly audit of controlled drugs records. We found that CD audit actions plans/policy were out of date and required a review.The senior management team was aware of this.
- Medication administration audits showed 100% compliance rates.
- Staff were required to attend training and complete the e-learning, as well as medication competencies prior to being able to administer these drugs. Staff had completed 'medicine for you' training and were encouraged to report errors in an open and honest way.
- The pharmacy department monitored storage of medication in refrigerated units and logged daily temperature checks, which were all within the correct limits. The pharmacist visited each ward daily.
- All controlled drugs were stored in appropriate locked cabinets.

Records

- We observed 10 patient records and found all were stored securely and no patient identifiable information was visible to people attending the ward. All records were paper files. All were fully completed records in black ink and with legible handwriting.
- We found the storing of theatre logs to be inappropriate. Logs were archived in a storage cupboard, which was not locked or secure at the time of inspection. The storage area also contained other items such as general storage. We raised the concern during the inspection and the door was secured immediately.
- We found a high standard of documentation on surgical wards with written records of pre- assessment in anaesthetic and nursing notes. All patient records contained admission records, medicine chart, pre-assessment information, risk assessment, nursing notes and WHO checklist (including instrument count, implant number and recovery care). All documents were legible, signed and dated.
- The health records standards audit January 2016 to March 2016 showed 79% of records were completed appropriately. Action plans were in place to reduce poorly recorded entries. Discussions were held with staff and reminders sent by email about the quality of recording.

Safeguarding

- Safeguarding training was undertaken through mandatory training. We found that 92% of staff had received safeguarding vulnerable adults level one training and that 90% of staff had received safeguarding children and young adults level one training against a hospital target of 85%. The matron held level three safeguarding training for children and young people. The hospital no longer undertook surgical procedures for children.
- The medical staff were aware of how to report safeguarding issues and relayed the process with confidence when asked.
- When we spoke with nursing staff, they demonstrated a good level of knowledge in relation to safeguarding triggers, forms of abuse and the processes followed.
- We saw information regarding Female Genital Mutilation (FGM) reporting, staff guidance, process and procedure.
- The hospital had no safeguarding incidents from January 2015 to December 2015.

Mandatory training

- The hospital training performance for surgical services showed mandatory training completion results were predominantly above the hospital target of 85%.
- The standard compliance rate was 90% overall. For example, training data showed Level 1: incident

reporting training was 96%, fire safety 91%, health, safety and welfare 91%, managing stress 97%, whistleblowing 96%, basic life support (BLS) 75%, and information governance training completion rate was 92%, The corporate induction, moving and handling training, violence and aggression level one and two training courses achieved 100% attendance.

- All staff we spoke with confirmed they were up to date with their mandatory training.
- Senior managers told us that training programmes were embedded and robust due to Nuffield Health training academy programmes.
- Clinicians employed by the local trusts underwent training through their trust and reported training outcomes to Nuffield Health through appraisal.

Assessing and responding to patient risk

- Nuffield Health used the Modified Early Warning Score (MEWS) risk assessment system. This allowed staff to record observations, with trigger levels to generate alerts, which helped with the identification of acutely unwell patients. Audit of MEWS score completion rate showed compliance of 96%.
- MEWS risk assessments, sepsis-screening tools were used, and we saw evidence of full completion. The staff we spoke with were aware of escalation procedures and provided examples such as when a patient doesn't pass urine they were scored higher on the MEWS tool, information was shared with the consultant, observations increased and where appropriate treatment provided. Patients who visited pre-assessment began the care pathway. We found evidence of comprehensive risk assessments in surgical records.
- The hospital ensured compliance with the Five Steps to Safer Surgery through application of the World Health Organisation (WHO) surgical checklist (including instrument count, implant number and recovery care). The WHO checklist audit showed note completion at 100%. The WHO checklist was completed in real time and the 100% completion outcome shown during the audit was based on 50 audits per quarter in real time (25 from records / 25 from observations). We chose ten records at random and found all had fully completed surgical checklists.
- Risk-based pre-operative assessments followed a very detailed care pathway with different pathways for different patients. Staff obtained complete basic medical information by telephone during the initial contact. Further information was gathered when the patient presented for appointment.
- There were strict criteria which the hospital followed to ensure the safety of patients, if the risk was too high, the surgery would be cancelled for example where a patient had a 40+ Body Mass Index (BMI), staff would seek further assessment from the Anaesthetist or Consultant or refer back to the GP.
- Nuffield Health recorded data on the number of patients who were refused surgery based on risk. If a patient were too high risk, Nuffield health did not accept the referral from the local trust.
- There was a local service agreement for the transfer of complex patients or those with multiple co-morbidity due to the hospital not having a level 2-care facility (High Dependency Unit).
- There was a clear procedure in the event of a major haemorrhage and obtaining blood components in such an emergency. Two units of emergency O RhD negative were kept in the fridge in red bags in the emergency O negative section of the blood fridge. An electronic system (the Blood Audit Release System) (BARS) for patient identification and specimen labelling was used. A Nuffield Health Blood Transfusion Care Pathway had been developed to ensure that patient care during a blood transfusion was standardised and followed good practice guidelines.
- Clinical audits included VTE, risk assessment, safety thermometer and moving and handling, all had target outcomes of 100%. Falls (85%), consent (98%), WHO checklist (100%), MEWS (96%), and clinical handover (96%)
- Anaesthetists were available post-operatively. However, it was identified that some left before they should and although the patient was awake and well, they did not wait until the patient left the recovery area, which was best practice. We established that the anaesthetists attended the WHO surgical checklist sign out prior to leaving theatre.

Nursing staffing

- In theatres we found a staffing ratio of nurse manager to nurse team leader of 1 to 3, a ratio of team leader to

nurse 1 to 4.7, a ratio of nurse to care assistant 1 to 0.2 and a ratio of nurse team leader to operating department practitioner (ODP) 1 to 1.3. This met national guidance.

- Ward staffing levels were determined by following the NICE guidance tool Safe Staffing Recommendations 2014. Staffing levels were calculated on a weekly basis to meet expected patient levels. These numbers were re-assessed on a day-to-day basis ensuring safe staffing with a ratio of 1:5 patients per qualified nurse and two healthcare assistants per early/late shift with a reduction in staff numbers to 1:6 patients overnight with a healthcare assistant (HCA) on duty on every operating day. The nurse in charge of each shift had a smaller patient load, which allowed time to review the next day's lists and staffing. The ward manager had two clinical and two non-clinical days but was based on the ward and available for help and support if it was required.
- We found that actual staffing rates were in line with planned staff rates during the inspection. We received six randomly chosen rotas between January and March 2016 and observed the same findings.
- We noted occasional use of agency staff (less than 20%) for all inpatient and hospital-wide staff groups in the reporting period (January 2015 to December 2015), except for nurses in January 2015 when it was moderate (between 20% and 39%).
- All bank staff completed an induction plus medical devices training.
- Sickness levels showed low sickness rates (less than 10%) for nurses and ODP. There were high sickness rates for health care assistants January to December 2015 (20% and over) except November 2015 and high sickness rates for ODP's in November and December 2015 (20% and over). However, these were based on low numbers of staff.
- Staff turnover was 6% for nurses with no staff turnover for HCA or ODP between January 2015 and December 2015.
- The ward organised handover sessions with one team of staff three times per day. During handover, staff discussed patient lists with the theatre manager who handed over to the recovery team. The ward clerk opened the theatre list on the computer for easy access to information.
- There was an out of hours on call system. There were usually two scrub nurses, one anaesthetist, and a recovery nurse on call. There was a process for staff to follow which started on the ward regarding who makes the call to the consultant and theatre staff.
- The Registered Medical Officer (RMO) attended night-time handover and received a printed list of all patients.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.

Surgical staffing

- The Registered Medical Officer (RMO) on duty was Advanced Life support (ALS) and Paediatric Advance Life Support (PALS) trained and was available for assistance 24 hours per day, 7 days per week.
- All patients were admitted under a named consultant who had clinical responsibility for their patient during their entire stay.
- There was a named anaesthetist responsible for the patient along with their named surgeon. In any circumstance where the practitioner was not available, cover was arranged from the colleague in the same speciality.
- All consultants awarded practising privileges agreed to abide by the Nuffield Health practising privileges policy, and provided the organisation with standard information showing they fulfilled the criteria. All consultants maintained registration with the GMC and were on the specialist register.
- There was a senior management on call rota in place seven days per week. This rota was circulated and all staff were aware of the senior contact for the hospital each week.

Major incident awareness and training

- Potential risks were taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.
- Arrangements were in place to respond to emergencies and major incidents such as fire, flood, loss of vital services, bomb and bomb threats, pandemic flu and severe adverse weather conditions.
- Nuffield Health Newcastle had tested back up emergency generators in case of failure of essential services.

Good

Surgery

- An emergency generator was in place, which had a Diesel tank capacity 1000 litres, allowing for approximately 12 hours running time at full load.
- There were emergency pharmacy supplies available for 3-5 working days for drugs and 3-5 working days of consumables for operations, and 3-5 working days for ward supplies.
- In the event of the HSSU hub being affected by an incident that closes the service to the hospital temporary arrangements have been agreed with another organisation to sterilise instruments. HSSU hub own contingency plan would be activated.

Are surgery services effective?

Good

We rated effective as good because:

- Patients were treated based on national and local clinical guidelines. A range of standardised, documented care plans were in place across surgery.
- Nurses discussed pain relief with elective patients and provided information on the type of pain relief they could expect to receive as part of their procedure. Pre-assessments offered tailored nutrition and hydration guidance to patients and provided all elective patients with fasting instructions to follow on the day of their surgery.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. Records showed 100% of staff within the surgical services department had an up to date appraisal.
- Patients were consented for treatment in line with national and local guidelines. They received information about the risks, benefits and alternatives to treatment.
- Patients assessed to be at risk of Venous Thromboembolism (VTE) were offered VTE prophylaxis in accordance with national guidance. The VTE audit show 100% compliance. Patient Reported Outcome Measures (PROMS) data for hip, knee and groin hernia were in line with national averages.
- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patients care and treatment. Care was coordinated between pre-assessment, wards and theatre staff ensuring all teams was involved in effective care delivery. We found handover and transfer processes in place to ensure consistent multidisciplinary care delivery when patients were moving between teams or services, including referral and discharge.

Evidence-based care and treatment

- We found that patient treatment was based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, and The Royal College of Surgeons.
- Nuffield Health Newcastle rarely received patients with mental health difficulties. However, staff were aware of the rights of people subject to the Mental Health Act (MHA). They advised they would speak with the matron if they were uncertain.
- Patients assessed to be at risk of Venous Thromboembolism (VTE) were offered VTE prophylaxis in accordance with NICE guidance. The VTE audit show 100% compliance.
- There were eleven cases of unplanned transfer of an inpatient to another hospital in the reporting period (January 2015 to December 2015). The rate of unplanned transfers (per 100 inpatient discharges) had fallen over the same period.
- There were three cases of unplanned readmissions of inpatients to other hospitals in the reporting period (January 2015 to December 2015). The rate of unplanned readmissions (per 100 inpatient discharges) had fallen in the same reporting period.
- Nuffield Health as a group had participated in The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) audits and was progressing towards the Macmillan Quality Mark status.
- The service did not collect Q-PROMs for patients receiving cosmetic surgery. However, Nuffield Health was engaging with the Royal College of Surgeons to look at aligning coding for cosmetic surgery to support a defined set of performance measures and to supply the data to the Private Healthcare Information Network (PHIN).
- The quality and safety dashboard from October 2015 to March 2016 showed consistency in quality across the four domains of safe, effective, caring and responsive. All targets across the period were within the expected limits.

Good

Surgery

Pain relief

- Patients told us that when they experienced physical pain and discomfort staff responded in a compassionate, timely and appropriate way.
- Pain relief stickers were placed on patient's files to advise what pain relief a patient was taking prior to surgery.
- There was no pain team. The named nurse who could access support from an anaesthetist monitored pain. MEWS included a pain score, which was reviewed at every assessment. On discharge, the RMO and anaesthetist discussed and reviewed pain medication with the patient and the RMO would then prescribe.
- Ward pharmacists regularly reviewed drug records for pain medication. Various pain relief methods were used for major surgery to assist with pain relief post-operatively, which improved patient comfort.
- Nurses within pre-assessment discussed pain relief with elective patients and provided information on the type of pain relief that patients could expect to receive as part of their procedure. Patients were given information leaflets on pain relief.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed during their pre-assessment. Food allergies where highlighted and a red band was provided for patients, kitchen staff and theatre staff were also made aware.
- There was an option of three antiemetic's following surgery to aid the effective management of patient nausea and vomiting.
- Patients using services had access to dietician services post operatively if required, from the acute referring trust. Patients receiving bariatric surgery had access to dietician from the acute trust prior to any surgical procedure taking place at Nuffield Health Newcastle. Ongoing dietician involvement was by the GP and consultant.
- Pre-assessments offered tailored nutrition and hydration guidance to patients and provided all elective patients with fasting instructions to follow on the day of their surgery.
- PLACE scores showed 98% in quality of food.

Patient outcomes

- All patients for joint replacement surgery were asked at pre-assessment to consider being registered for the National Joint registry, with good compliance from patients this monitors infection and revision rates. Patients were also given the opportunity to participate in Patient Reported Outcome Measures data collection (PROM's) for hip replacement, knee replacement, varicose veins and inguinal hernia. The hospital had recently taken part in an electronic PROM's reporting pilot scheme for shoulder, carpel tunnel, and transurethral resection of the prostate(TURP), cataract and septoplasty.
- PROMS for groin hernia showed Nuffield Health Newcastle outcomes were in line with the national average for EQ-5D (measure of generic health status) index with 58 records checked at audit, statistics showed 30 had improved, 12 unchanged, 16 worsened. EQ-VAS (overall health related quality of life) showed that out of 58 records checked 20 had improved health, 10 unchanged, 28 worsened health.
- PROMS for hip were in line with national average for EQ-5D index. Out of 34 records, 31 improved health, and none worsened. EQ-VAS out of 34 records 21 had improved health, and seven worsened. Oxford hip score showed that out of 39 records 37 improved, and none worsened.
- PROMS knee were in line with national average for EQ-5D index. Out of 39 records checked at audit, 27 had improved health, 9 worsened. EQ-VAS out of 38 records 20 had improved health, 12 worsened. Oxford knee score out of 42 records 38 improved health and four had worsened.
- The hospital monitored their own outcomes for hips, knees; breast surgery and abdominoplasty with a 30 day follow up telephone call. Information was gathered from the incident reporting system on patients requiring re admission, transfer to another healthcare provider, unplanned returns to theatre, incidents relating to a thrombolytic event or any other significant events.
- Most patients who underwent joint replacement surgery were reviewed in clinic. For patients funding their own procedures, the terms and conditions offered support for any untoward outcomes relating to surgery for an indefinite length of time without additional cost to the patient. The governance framework ensured that a range of outcomes were reviewed and discussed.
- On a monthly basis there was a report submitted to the corporate quality manager, this reviewed benchmarked data across the company. Hospital associated infections

were uploaded onto a corporate clinical SharePoint site, and hip and knee arthroplasty surgical site infections reported to public health England. The hospital was working within the expected targets.
- The hospital reported a 0.06 per 100 patients unplanned return rate to theatre between January 2015 and March 2015 with no patients between April 2015 and December 2015.
- The provider did not participate in the Anaesthesia Clinical Services Accreditation scheme (ACSA).
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. Recovery Plus was Nuffield Health's flagship recovery programme and was available free of charge to private patients at Nuffield Health hospitals. Recovery Plus provided patients with a personal recovery programme, health check, exercise and diet advice, together with a three-month membership at a Nuffield Health Fitness & Wellbeing Gym.

Competent staff

- Records showed 100% of staff within the surgical services department had an up to date appraisal.
- Staff we spoke with felt able to discuss their training needs with their line manager. Staff discussed opportunities to further their career and stated they were encouraged to undertake external university modules appropriate to their training needs.
- Senior managers recruited orthopaedic and general surgery nurses. If nursing staff were not specialist trained, staff were monitored and supported within their role.
- We found that managers ensured appropriate skill mix by enabling staff to access training and experience in other disciplines e.g. gynaecology. This additional experience was found to help provide effective cover in the department.
- We found that all staff had their own set of objectives, linked to their appraisal. Managers ensured staff set their own personal development objectives and encouraged development.
- There was no formal supervision or one to one meetings in place, but managers checked staff competencies during informal supervision and training records. Informal supervision was held as and when required. Support and guidance was available at all times.
- Staff stated that managers supported and encouraged staff through the revalidation process. There was information on the corporate intranet and reflective discussions took place during appraisal.
- Surgeon competencies were discussed through appraisal process. Nuffield Health Newcastle had plans to re-audit consultants and their practice. There were no regular case reviews of complex cases.
- Senior managers reviewed Scope of Practice (SoP) and appraisals to seek assurance that the consultant was delivering the same type of surgical procedures as they did within their own trust.
- Nuffield Health Newcastle reviewed the SoP annually. Appraisals and revalidation were undertaken by the consultants own trust. All consultants completed a Scope of Practice check and took this back to their own trust as part of their trust appraisal process. However, there was no formal secondary check that the consultant was performing the same type of surgery at Nuffield Health Newcastle as they did in their own trust. Consultants were expected to advise Nuffield Health Newcastle if anything had changed within their SoP.
- There was a new preceptorship programme in place for newly qualified nursing staff.
- We were informed that healthcare assistants attended the Royal College of Nursing 'Future of Healthcare' study days as a means of assurance that all HCA's were trained to the same level and standard.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patients care and treatment. Care was coordinated between pre-assessment, wards and theatre staff ensuring all teams was involved in effective care delivery.
- We found handover and transfer processes in place to ensure consistent multidisciplinary care delivery when patients were moving between teams or services, including referral and discharge.
- The ward staff at Nuffield Health Newcastle liaised with local trusts, local authorities, and GP's, to ensure the arrangements for discharge were considered prior to elective surgery taking place.

- Handover processes were in place to ensure the RMO received appropriate information about the patients and the surgery undertaken. This also ensured that all team members were aware of who had overall responsibility for each individual's care.
- Physiotherapist and x-ray department were involved in patient care and all teams communicated with each other.
- Before discharge, the pharmacist visited each patient to identify what medication was required. Each patient was given a discharge booklet that included a copy of their consent and key phone numbers. We found that the nurses discussed the booklet with patients before discharge.
- District nurses were involved in discussions prior to discharge to ensure patients received continuity of care
- The GP received a copy of the discharge letter sent to them on the same day of discharge. Details of surgery and implants used remained with Nuffield Health.
- There was no occupational therapist based within Nuffield Health Newcastle.
- The RMO provided medical support for all patients out of hours. Consultants were available on-call if required (for surgical patients).

Seven-day services

- On site, basic haematology and biochemistry tests were performed along with a blood transfusion service delivered to the hospital using BARS (Blood Audit and Release System). Out of hours was covered by pathology staff from Nuffield Newcastle (telephone cover) and with arrangements with a local NHS Trust (QE Gateshead) who also supplied blood products to the department on a use or return basis to minimise wastage.
- All three theatres were available Monday to Friday, weekdays 8am to 8pm and Saturdays 8am to 4pm. Theatre 2 was the designated emergency theatre out of hours.
- There was no access to radiology services out of hours. Staff transferred patients out to the local trust if they required urgent care.
- The physiotherapists provided support all day including Saturdays and up to 2pm on Sunday. There were five treatment areas and a small physiotherapy gym.
- Radiographers are on-call 24/7 and pharmacy was open until 5pm with an on-call service available from an on-call pharmacist for advice or the Royal Victoria Infirmary hospital if an urgent supply was needed.

Access to information

- When patients moved between teams and services, including at referral, discharge, transfer and transition, all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols.
- Discharge was communicated to GPs by letter on the day of the patient discharge.
- We found that GPs had direct access and could speak to a surgical team for advice on the phone as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that patients had consented to surgery in line with hospital policy and Department of Health guidelines. The matron told us cosmetic surgery patients were all offered a second appointment; and told they could come back as many times as they wanted prior to surgery. Patients were all offered a second appointment, but they did not have to take it, however they had to wait at least two weeks before surgery could take place. Patients received information about the risks and benefits for procedures such as breast augmentation and abdominoplasty.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction and this was supplemented by dementia training. Dementia care training became mandatory in January 2016.
- We found policy and procedures in place, ensured that capacity assessments and consent was obtained by the appropriate clinician. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications.
- Staff said they would speak to the GP and/or family if there were concerns regarding capacity. Staff reported that they would support the patient and their family through the best interest's decision making process.
- Staff advised they would source an Independent Mental Capacity Advocate (IMCA) if best interest decision meetings were required.

Good

Surgery

Are surgery services caring?

Good

We rated caring as good because:

- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- Patients and relatives said they felt involved in their care and they had the opportunity to speak with the consultant looking after them. Patients told us staff kept them well informed and explained the reason for tests and scans. Patient feedback was very complementary.
- Patients were treated courteously and respectfully and their privacy was maintained. Services were in place to provide emotional support. Patients were kept informed and involved in planning their treatment. Patients were able to make informed decisions about the treatment they received.

Compassionate care

- We spoke with ten patients who were consistently positive about the service they had received at Nuffield Health. All patients said they would return for surgery in the future if required and would recommend friends and family.
- During the inspection, we saw staff respect patient's personal, cultural, social and religious needs.
- We saw staff take the time to interact with people who use the service in a respectful and considerate manner. They were encouraging, sensitive and supportive towards patients and sought consent prior to our discussions with patients.
- Patients had call bells within arm's reach and stated that the response was quick.
- Staff stated they would be confident to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes if they encountered them.
- Staff ensured people's privacy and dignity were respected during physical and intimate care at all times. Patients had single rooms and had access to ensuite bathrooms.
- Each patient felt their privacy and dignity was respected and they were happy with the quality of care they had received.
- The national Friends and Family test showed that 99% of patients were happy with the service they received at Nuffield Health Newcastle.
- Internal patient satisfaction scores showed 90% of patients would recommend Nuffield Health Newcastle as a place to have treatment.
- PLACE scores showed 98% in privacy and dignity.
- Patients said: 'The service was excellent', 'no faults', 'communication very good', 'fantastic service', good variety of food', and 'staff were polite, respectful and friendly'.
- The Nuffield Health patient satisfaction survey reports data in a format that allows the hospital to compare its results with other Nuffield Health hospitals.

Understanding and involvement of patients and those close to them

- All patients said they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients and relatives said they felt involved in their care and had been given the opportunity to speak with the consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out and did their best to keep patients reassured.
- We saw ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- Patients we spoke with were complementary of the patient information booklets given prior to surgery. Patients felt they were better educated, supported, and prepared for their surgical procedures.
- All patients had a named nurse. Patient numbers were small enabling easier continuity of care.
- Private patients were advised about all possible costs that would be incurred in a timely manner at the initial consultation, again at pre-assessment and on admission.

Emotional support

Good

Surgery

- Staff spoke compassionately about their patients and had a clear understanding of the impact that a person's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Many staff were trained in counselling and were able support to patients as and when required. Patients receiving cosmetic, bariatric or breast cancer treatment received support from nurses as well as a psychologist if required.

Are surgery services responsive?

Good

We rated responsive as good because:

- Nuffield Health Newcastle had facilities to provide patients flexibility, choice and continuity of care.
- The hospital received referrals predominately from Newcastle Gateshead CCG, Northumberland CCG and North Tyneside CCG, plus a small amount from other locations. There was a service level agreement in place with the Newcastle upon Tyne Hospitals NHS Trust for the urgent transfer of patients who required a higher level of care.
- The hospital had an escalation policy and procedure to deal with busy times. Waiting times met national standards.
- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs. There was no religious support onsite. However, if patients wanted a visit with a religious or spiritual representative during their stay, staff would arrange this with external sources.
- Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability, or those whose first language was not English.
- We found that the service liaised with patients, families and carers when discussing discharge plans. Patients advised they were included in the planning process and staff ensured vulnerable patients where supported appropriately on their return home.
- Complaints were handled in line with the hospital policy and discussed at all monthly staff meetings. This highlighted any training needs and learning was identified as appropriate. The hospital director (HD) took overall responsibility for the management of complaints in line with Nuffield Health complaints policy.

Service planning and delivery to meet the needs of local people

- Nuffield Health Newcastle had facilities to provide patients flexibility, choice and continuity of care.
- We were informed that private patients did not receive priority over NHS patients. Urgency of need took priority over funding source. .
- New surgical opportunities and ventures were discussed with local trusts and during the planning, feedback was sought from the Nuffield Health surgical department, finance, and outpatients to establish staffing needs, and to formulate process as well as create standard operational practices.
- The hospital received referrals predominately from Newcastle Gateshead CCG, Northumberland CCG and North Tyneside CCG, plus a small amount from other locations. There was a service level agreement in place with the Newcastle upon Tyne Hospitals NHS Trust for the urgent transfer of patients who require a higher level of care.

Meeting people's individual needs

- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs. There was no religious support onsite. However, if patients wanted a visit with a religious or spiritual representative during their stay, staff would arrange this with external sources.
- Interpreting services were available for patients whose first language was not English. There was access to British Sign Language translation.
- 'This is me' personal information booklets were used with patients living with dementia. All staff were trained in dementia care and in the use of the 'This is me' personal information booklets.

Good

Surgery

- PLACE scores showed 76.7% for dementia care. We found some areas of the hospital layout to be problematic for those patients with dementia; colours were not clearly defined between walls and floor, floors were shiny, and there were no handrails along the corridors. The hospital were reviewing these findings to see what reasonable adjustments could be made to the environment to improve care for these patients.
- Two health care assistants and two qualified nurses were dementia champions and were part of the dementia community in which they attended meetings with other local providers. Staff also used the 'This is me' documentation for patients with learning difficulties.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. All were written in English. However, alternative languages and formats were available on request.
- Ward managers were clear about zero tolerance for discrimination.
- There were no mixed sex accommodation breaches due to all rooms being single rooms.
- Patients attending the Jesmond Clinic (cosmetic) received psychological support from staff and external counselling where required.
- Patients living with dementia or learning disabilities were able to have their carer or family member accompany them to theatre and be there when they woke up.
- Staff talked us through the actions taken when people using the service become delirious during their admission. It was explained that observation increased to every 15 minutes, staff numbers would increase as necessary, and on occasion one to one support provided.
- Discrimination, including on grounds of age, disability, gender, gender reassignment, race, religion or belief and sexual orientation was avoided when making care and treatment decisions.
- There was good access to the wards. There were lifts available and ample space for wheelchairs or walking aids in each area. We found that the facilities and premises were appropriate for the services that were planned and delivered.
- We found that the service liaised with patients, families and carers when discussing discharge plans. Patients advised they were included in the planning process and staff ensured vulnerable patients when supported appropriately on their return home.
- The pre-assessment team advised us that information was sent to the ward regarding details of any special requirements for the patient e.g. if patient lived alone or needed a special mattress.

Access and flow

- Referral to Treatment Times (RTT) within 18 weeks (target 90%) showed that Nuffield Health Newcastle consistently met standards for admitted NHS patients in 2015.
- If a patient required a transfer to an acute hospital, the RMO and consultant would review them in the first instance. The consultant made a decision, spoke with the accepting ward at the local acute hospital, and provided a verbal handover. Written information followed with the patient. Once a patient was transferred, the admitting consultant became responsible with daily contact from Nuffield health.
- The service prioritised care and treatment for people with the most urgent needs. Patients were not prioritised by payment type for example, private over NHS funding.
- Patients said they were seen and received treatment in a timely way and that suited them.
- Discharge was communicated to GPs by letter on the day of the patient discharge.
- There were high levels of cancellation rates in 2015. It was felt this was due to over booking of appointments for surgery. Staff worked in conjunction with the bookings team to check every consultant's session time over a two-month period to prevent over booking and to monitor themes and trends. This had now improved.
- We were advised that operations would be cancelled if theatres were running late meaning that the following surgical patient would not be seen at an appropriate time (before 9 pm). Patients were kept informed of changes to their surgery times and of cancellations.
- Nuffield Health Newcastle rarely dealt with unplanned surgery, however there were protocols and processes in place for this such as unexpected return to theatre. However, we were advised that a return to theatre would be prioritised if there was a post-operative problem such as a bleed.

Good

Surgery

Learning from complaints and concerns

- The hospital director (HD) took overall responsibility for the management of complaints in line with Nuffield Health complaints policy. When complaints involved any aspect of clinical care the matron lead on the investigation ensuring the relevant head of department (HOD) was fully involved so that the investigation became a 'lessons learnt' experience for staff.
- When a complaint involved a consultant with practising privileges, a process was followed to address concerns with the consultant, and involved the MAC Chairman if necessary.
- The PA to the HD managed and logged complaints ensuring time lines were adhered to. We were told that the HD and matron discussed clinical complaints as soon as they arrived and commenced an investigation. We reviewed five complaint files. There was a polite, efficient and succinct response to the complaints. All letters of complaint were acknowledged on the day of receipt, the response date was met in all cases and apologies were provided. The complaints highlighted a number of learning outcomes for staff (improved team communications and better costing of treatments) and all the complainants were happy with the responses. One complainant received a partial refund due to inconvenience caused.
- Complaints were discussed at Senior Management Team (SMT) level on a weekly basis. Information was cascaded through a number of forums including monthly at clinical heads of department, integrated governance and quarterly at MAC meetings. Additionally, the heads of department fedback outcomes and lessons learned at their own monthly department meetings.
- The hospital acknowledged complaints within two working days of a compliant being received, and aimed to provide a full response within 20 working days. We reviewed five complaints and saw that the hospital were meeting their standards
- The hospital provided 'How to make a comment or formal complaint' booklet to encourage and enable patients to provide feedback of compliments or complaints. There was also an opportunity to provide feedback through the Patient Satisfaction Survey Questionnaire, hospital website enquiry/ complaint form, written complaints and verbal complaints (which were then recorded and actioned by staff). Nuffield Health's "how to make a comment" or formal complaint books were displayed at various locations across the hospital, which explained the process.
- Staff managed patient complaints at the earliest opportunity to resolve any issues. Staff were encouraged to make their first response an apology to the patient, to record the details, or to contact a more senior member of staff.
- The matron telephoned patients who made a verbal complaint. Letters of apology were sent and if appropriate travel expenses were refunded to patients, and consultant's fees waived.
- The monthly Patient Satisfaction Survey was discussed at integrated governance meetings and head of departments shared comments and scores with their staff.

Are surgery services well-led?

Good

We rated well-led as good because:

- Senior managers had a clear vision for surgical services. Staff were able to repeat and discuss its meaning. Clinical governance and ward meetings were held each month. The risk register was updated following these meetings and we saw that action plans were monitored across the service.
- Staff said managers were available, visible, and approachable. They also said leadership of the service and staff morale were good with staff supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.
- Staff and managers had a vision for the future of the department and were aware of the risks and challenges faced by the department. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed.
- The hospital engaged with staff and patients were given opportunities to provide feedback about their

experiences of the services provided. Staff and managers told us there was an open culture. They felt empowered to express their opinions and felt they were listened to.
- Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

Vision and strategy for this this core service

- We met with senior managers who had a clear vision, which was embedded with staff. Staff were able to explain the hospital values of Enterprising, Passion, Independence and Care (EPIC).
- The hospital worked in partnership with local NHS trusts to maintain financial sustainability through local service agreements. .
- We saw a strategy for achieving Nuffield Health priorities to achieve and deliver good quality care. Staff felt the strategy was realistic and felt Nuffield Health Newcastle required more money to make it fully achievable e.g. to buy more equipment.
- Staff knew and understood the strategy and their role in achieving it. All staff attended a study day about plans for Nuffield Health and the changes within the organisation, such as the 10-year strategy plan, values, and vision.

Governance, risk management and quality measurement for this core service

- We saw an effective governance framework to support the delivery of the strategy and good quality care with all staff clear about their roles, responsibilities and level of accountability.
- We reviewed the human resource files of three members of the senior management team, namely matron, finance manager and sales and services manager. All relevant pre-employment checks were evident such as identification, written references (and verbal in one case), checking of qualifications (Association of Chartered Certified Accountants for finance, Nursing and Midwifery Council Disclosure and Barring Service and Occupational Health clearance). All had completed the new starter induction and HR policy checklists were signed (except sales and services manager, which was completed in our presence). The files also contained evidence of mandatory training completion (including refreshers) and appraisals.
- There were 231 consultants registered with Nuffield Health Newcastle. All consultants awarded with practising privileges agreed to abide by the Nuffield Health practising privileges policy, and provided the organisation with standard information showing they fulfilled the criteria. All consultants maintained registration with the GMC and were on the specialist register.
- Prior to practising privileges being granted, surgeons must provide evidence that they hold an appropriate level of valid professional indemnity insurance. Records showed these were in place
- Medical Advisory Committee (MAC) minutes were comprehensive, discussed new policies, cancelled surgery, consultant biennial reviews, transferred patients, returns to theatre and re-admissions to hospital.
- There were assurance systems and service performance measures in place to monitor quality. Nuffield Health Newcastle dashboards (January 2015 to December 2015) showed the hospital was performing within expected targets.
- There was alignment between the recorded risks and what staff said was 'on their worry list'.
- There was a clinical governance group responsible for reviewing surgical procedures. Information from the governance group was shared with the Board and MAC.
- The roles and responsibilities of the MAC were set out and available.
- Consultant surgeons inviting external first assistants, NHS staff or others into theatres took responsibility to ensure assistants completed the appropriate paperwork and provided Nuffield Health with the appropriate documents as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.
- Nuffield Health gained assurance that medical practitioners involved in cosmetic surgery in the independent sector, informed their appraiser of this in their annual appraisal and maintained accurate information about their personal performance in line with national guidance on appraisal for doctors. Consultants requested a form completed by Nuffield Health, prior to appraisal, which stated specialist surgeries undertaken. This form was passed to the local trust appraiser. The appraisal was then shared with Nuffield Health.

- Reports detailing significant incidents were discussed at clinical heads of department, integrated governance, Board meetings and Medical Advisory Committee. Patient's feedback was through the patient satisfaction survey, which was cascaded to staff, action plans were completed addressing areas of concern. Matron also completed succinct summaries for distribution to staff.
- Leaders ensured that employees who were involved in the performance of invasive procedures were given adequate time and support to be educated in good safety practice, to train together as teams and to understand the human factors that underpin the delivery of safer patient care.

Leadership

- Staff were confident that leaders had the skills, knowledge, experience and integrity that they need to manage the organisation. This included skills such as capacity, capability, and experience to lead effectively.
- Many staff highlighted that relationships with senior managers were "really good and strong".
- Managers highlighted good relationships with senior managers and noted a close working relationship when creating and developing business plans.
- Ward and theatre staff described senior management as 'fantastic' and 'fabulous' when discussing visibility and approachability of managers.
- Staff said that leaders generally understood frontline staff e.g. gave nurses protected time for IPC. It was felt that managers listened and responded to requests when staff explained the rationale of the request.

Culture within the service

- Staff we spoke with stated they were respected and valued. They stated that the organisation as a whole was supportive and showed appreciation of the staff.
- Behaviour and performance inconsistent with the vision and values of the organisation was dealt with through appraisal, regardless of seniority. When necessary, issues were addressed on a one to one basis.
- We found the culture encouraged candour, openness and honesty.
- Staff felt that their safety and wellbeing was important to the organisation. Staff explained that they were given access to Nuffield Health gyms as a way of promoting physical wellbeing.
- Staff and teams worked together, appeared to resolve conflict quickly and shared responsibility to deliver good quality care.
- We saw systems to ensure people using the service were provided with a statement that included terms and conditions of the services being provided, and the amount and method of payment of fees.

Public engagement

- People's views and experiences were gathered through patient forums. However, attendance had been low.
- The hospital worked closely with the local Jehovah witness hospital liaison group, who provided staff training, information leaflets such as what to do prior to surgery and alternatives to blood transfusion.
- People, who use services, were actively engaged and involved in decision-making around their own care and treatment. All patients said they were encouraged to be involved in their care planning and recovery.

Staff engagement

- Staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.
- It was stated by staff members that when concerns were raised senior managers took appropriate action.
- Staff engagement took place regularly through a Leadership MOT, a survey that went out to staff for feedback and evaluation. There were no additional staff surveys.
- Staff had access to the 'In the Loop' staff bulletin, which provided updates on developments and changes. Emails regarding management changes were circulated as necessary and there was a monthly magazine and newsletter specifically about Nuffield Health Newcastle.
- Staff attended a forum on a monthly basis with additional monthly engagement meetings held on the ward, which were minuted
- Staff stated they felt encouraged, supported and helped with revalidation.
- Staff were involvement in planning care and treatment including healthcare assistants.
- Staff had access to study days and was encouraged to develop their skills.

Innovation, improvement and sustainability

Good

Surgery

- The hospital introduced a suction machine, which cleaned all bodily fluids from the theatre floor. It was a completely closed system for all bodily fluids and had improved IPC within theatres.
- There was a good structure in the department where everyone had lead responsibility for a key function for example IPC and medical devices.
- The Care Certificate was introduced to all HCAs so staff could be trained to an equal level. Nuffield Health Newcastle was the pilot site for the Care Certificate. The first HCA who achieved it was from Newcastle and the training had since rolled out to all HCAs.

Good

Outpatients and diagnostic imaging

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

Information about the service

The hospital provided outpatient and diagnostic imaging services to NHS and other funded (insured and self-pay) patients from the North East, Cumbria and further afield. The hospital site was well served by public transport links and provided free on-site parking. The hospital had an outpatient department comprising 18 consulting rooms hosting a number of different specialities including orthopaedics, ophthalmology, gynaecology, cardiology, oncology and cosmetic surgery. The Jesmond Centre offered dedicated outpatient consultations for cosmetic and weight loss surgery. The hospital also provided outpatient consultations to children under the age of sixteen.

In 2015, there was 24,990 out-patient attendances, 11,902 were first attenders and 13,088 were follow up visits. 3,395 were NHS funded patients (960 first appointment and 2435 follow up) and 21,595 were classified as 'other funded' (10,942 first attenders and 10,653 follow-up). Children under 16 accounted for 423 (3.5%) first appointments and 288 (2.2%) follow-up appointments. The three specialisms with the greatest number of attendees were in orthopaedics (7,833), cosmetic surgery (2,436) and general surgery (2,276).

The hospital diagnostic imaging department provided on-site imaging, fluoroscopy, mammography and ultrasound five days a week until 8pm and on Saturday morning. The department had the use of a mobile x-ray machine and an image intensifier. The department completed 382 mammography examinations, 3,775 projectional radiography, 532 theatre and fluoroscopy and 2,137 ultrasound scans in 2015. A 24-hour seven-day week on-call rota was in place.

The hospital had a static MRI (magnetic resonance imaging) scanner and a CT (computerised tomography) mobile unit, which were operated by third parties. 6,106 MRI and 717 CT exams were performed in 2015.

Endoscopy services were provided in theatre with on-site instrument decontamination and clean storage areas. In 2015, the department carried out 313 diagnostic colonoscopies and 236 diagnostic gastroscopies.

Pathology services at the hospital were provided as part of the wider Nuffield Health Pathology resource. The facility held Clinical Pathology Accreditation (CPA) and was Medicines and Healthcare Products Regulatory Agency (MHRA) compliant for Base Quality Score Recalibration (BQSR) 2005. The department were awaiting transitional inspection as part of ISO15189. On-site the pathology service provided haematology, biochemistry and blood transfusion services. Histological and microbiological specimens were sent to specialist labs in Warwick and Leeds respectively. Out-of-hours, telephone advice was provided by hospital pathology staff and arrangements for pathology services were provided by a neighbouring NHS trust.

During the inspection, we visited the outpatient, diagnostic imaging and pathology departments. We spoke 14 members of staff including medical, nursing, radiography, laboratory, administrative and managers. We had the opportunity to meet 9 patients and their family members and we observed care and patient interactions in all departments. We reviewed 10 patient medical records including electronic diagnostic imaging records.

Previous inspection findings showed there were no areas of non-compliance found in this core service.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated Nuffield Health Newcastle upon Tyne Hospital as good in safe, caring, responsive and well-led because:

- Staff were confident in reporting and investigating incidents using the hospitals reporting system. Staff received feedback from reported incidents, lessons learnt were cascaded and positive changes to practice followed.
- Targets for internal safety measures such as infection prevention and control audits and mandatory training were met.
- The hospital had robust procedures in place to assess and respond to patient risk.
- Staff were flexible in their working patterns to support the needs of the service and patient requests.
- Evidence-based practice, national guidelines and best practice standards supported patient care, which was delivered by skilled and competent practitioners.
- Patients were treated holistically and informed about treatment options. Staff interactions were kind, compassionate and genuine. Patients acknowledged the quality of the care they received.
- Service planning and development was patient focussed with efficient turnaround times for investigation results and clinic appointments allowing care to proceed immediately.
- The hospital managed the complaints process with efficiency and an aspiration to promptly resolve issues to the satisfaction of all parties. Response letters to complaints were sensitive, honest and apologetic.
- Departments had good governance and risk strategies with compliance against radiation legislation particularly robust.
- Local and senior managers within the hospital were visible, supportive and approachable.
- A number of service improvement projects were driven by patient feedback and were innovative in their approach to delivering a quality service to patients.

However:

- Some reception areas were not conducive to private conversations, which could inadvertently lead to breaches in confidentiality or data protection.
- Patients were sometimes confused by the signage and branding situated in the second floor outpatient department, which combined as 'The Jesmond Clinic' providing cosmetic and weight loss services.
- Clinic waiting times were not displayed and the process of informing the patients of real or potential delays was variable which may affect overall patient satisfaction.
- The hospital did not always maintain a clinical record on site following each patient attendance. Staff were working with the consultants to share information in order to produce a clinical patient record. The hospital planned to progress toward an electronic based patient record in the coming year.
- Some room risk assessments in radiology were generic and lacked specific detail.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff were confident with the process for reporting and investigating incidents using the hospital's electronic reporting system. Lessons learnt from incidents had brought about positive changes in practice.
- The hospital was clean, well-furnished and equipment was checked to ensure compliance with required safety checks prior to patient use.
- Compliance with required mandatory training was very good across all departments and all levels of staff.
- All departments were appropriately staffed to meet patient need. Outpatients and diagnostic imaging staff were flexible in the working patterns to meet the needs of the service and patient requests.
- There were robust procedures in place to assist staff in assessing and responding to patient risk and the hospital worked closely with radiation protection specialists to ensure patient safety in diagnostic imaging.
- Staff confirmed an understanding of safeguarding procedures and major incident plans.

However,

- Some chairs in waiting areas were covered with material making thorough cleaning difficult. There was a replacement plan in place.
- There was no designated disabled access toilet in the diagnostic imaging department therefore some patients had to leave the department to access these facilities in a near-by area of the hospital.
- The hospital confirmed there was insufficient storage space for medical records however off-site storage was accessed. There was an inconsistent approach to keeping a record of clinical consultations on site however hospital staff were working with their consultants to address this. The long-term plan was to move to an electronic based records system to minimise space required and ensure ease of access to clinical records.
- Although signage was good, for those patients who had out-patient appointments on the second floor, some expressed their confusion when presenting to 'The Jesmond Clinic' reception area when they had not attended for cosmetic or weight loss surgery.
- Some reception bases were situated within open plan waiting areas where personal discussions could be overheard at times. There were facilities for private discussions if required.
- Local written procedures in radiology should clarify what annotation is required by operators and practitioners to satisfy correct safety checks have been made.
- The hospital should ensure there is a robust x-ray equipment capital replacement plan to ensure future reliability and quality.

Incidents

- All staff were aware of their responsibilities to report incidents using the hospital electronic incident reporting system.
- Staff were encouraged to and were confident in reporting concerns. Staff confirmed the types of incidents they would report and these ranged from 'near-miss' events such as wrong patient demographics recorded on documents to incidents involving patient harm.
- Staff recorded the risk grade and severity of an incident using the database and added relevant background, which allowed managers to investigate further where required.
- There were 488 incidents reported in 2015. Of those, 15 (3.1%) were generated from outpatients, 32 (6.6%) were from diagnostic imaging and 16 (3.3%) were from pathology.
- The majority (57 of the 63, equivalent to 90%) of these incidents were classified as no/low harm. There were some trends namely poor specimen labelling, electronic misfiling of radiology reports and user errors with the blood audit release system (BARS). Seven incidents fell within the moderate harm classification. Three were post-procedure infections, one related to an identified deep vein thrombosis, one identified an issue in radiology reporting and one detailed a reaction following a diagnostic procedure.
- Overall, within the 488 incidents, the hospital classified 285 (58.4%) as clinical incidents, namely those, which involved a patient.

Good

Outpatients and diagnostic imaging

- We reviewed a root cause analysis investigation report (RCA) following one of the reported moderate harm classified incidents. The report contained a detail background and chronology of events, issues around standards were highlighted, contributory internal and external factors were considered and identified lessons were learned. The report was of a good quality and was completed in a reasonable timeframe.
- The services reported no never events (serious incidents that are wholly preventable which have the potential to cause serious potential harm or death. Harm is not required to have occurred for an incident to be categorised as a Never Event.) or serious incidents in 2015.
- There were no expected or unexpected deaths in 2015. Mortality and morbidity cases were discussed at integrated governance meetings on an as required basis.
- The hospital made no statutory notifications and there had been no coronial preventing future death reports in accordance with Coroners (Investigation) Regulations 2013.
- There were no reportable radiation incidents in accordance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) at the hospital. Any such incident was reported internally, highlighted and discussed at the radiology expert advisory group (EAG) and reported externally under IR(ME)R or to the Health and Safety Executive (HSE) under Ionising Radiation Regulations 1999 (IRR99).
- The national radiology adverse events report covering October – December 2015 (Q4) recorded 224 overall events across all Nuffield Health locations, 96% of which were no or low harm events. 12 (5.4%) of those reported were from the diagnostic imaging department. Two were classified as moderate harm however, both were unrelated to direct patient care provided in the department.
- In accordance with Royal College of Radiologist (RCR) and patient safety (NPSA) standards for the communication of critical, urgent or unexpected significant radiological findings, staff in radiology confirmed these results immediately to the referrer. This process was by telephone, fax, email and followed up in writing to ensure the information was passed as quickly as possible.
- Managers discussed clinical incidents at the monthly Clinical Heads of Department (CHODs) meeting.
- Feedback and lessons learnt from incidents were discussed with individual staff members concerned. Wider learning was cascaded to staff in team meetings, staff bulletins and by intranet updates.
- Staff could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice. In outpatients, staff improved processes following the rejection of a specimen in pathology when patient details were not correct. In diagnostic imaging, staff completed x-ray simulation exercises in the event of patient deterioration.
- Staff we spoke with were aware of the principles of Duty of Candour (a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person) and confirmed knowledge of the local hospital policy. Managers explained that patients were informed verbally at the earliest opportunity when an incident had occurred. Staff investigated the associated incident and updated the patient of the outcome in writing which included a formal apology.
- We reviewed a root cause analysis investigation, which showed that Duty of Candour had been applied.

Cleanliness, infection control and hygiene

- All patient areas visited were visibly clean and clutter-free. There were cleaning schedules and cleaning rotas on display in all areas. All equipment was observed to be clean.
- The hospital completed a monthly cleaning audit of all departments benchmarked against area specific criteria. Between March – May 2016, outpatient's average compliance was 87.5%. The score had been reduced due to a problem with a broken water cooler. In diagnostic imaging, the average compliance score was 81.3% with comments made about marks being present on doors and walls requiring painting. In pathology, the average compliance score was 90%. The shortfall was due to blood roller/mixer not being captured by the cleaning schedule. Staff put actions in place to ensure compliance against identified shortfalls from the audit findings.

Good

Outpatients and diagnostic imaging

- The services were included in the Patient-led assessment of the care environment (PLACE) audit in June 2015. Overall, the hospital scored the same or higher than England average for cleanliness (100%) and condition appearance and maintenance (96%).
- The hospital held monthly infection prevention and control (IPC) meetings, quarterly infection prevention committee meetings and antimicrobial stewardship meetings with the consultant microbiologist. The services had a director of infection prevention and control (DIPC), an IPC lead nurse and IPC link nurses who had received specialist training. The IPC link nurses completed local departmental audits in conjunction with the wider Nuffield IPC agenda such as asepsis, bare below elbow (BBE), handwashing and environmental audits.
- At the time of our inspection, IPC mandatory theory and practical training compliance was at 75% in outpatients, 90% in pathology and 94% in radiology (against hospital target of 85%).
- In February 2016, the services engaged in the monthly IPC audit. Relevant to outpatients and diagnostic imaging, hand hygiene facilities compliance was recorded at 84% and hand hygiene observation of practice recorded 95% compliance. These results were consistent with previous monthly audits. The shortfall in the hand hygiene facilities result identified that some areas did not have soap and alcohol gel dispensers wall mounted.
- The services were involved in the hospital hand hygiene awareness day held in May 2016 to promote best IPC practice.
- There was infection control information displayed at reception points, in patient waiting areas and information booklets were available on information stands. The outpatient department had designed specific infection control and handwashing literature specifically for children.
- Staff in the services knew of the infection prevention strategy and policy. Staff were also aware who to contact for IPC advice and who within their department were the IPC link practitioner.
- We observed visitors, patients and staff washing their hands. We observed staff using hand gel between treating patients. Separate hand washing basins, hand wash and hand gel dispensers were available in the departments and patient areas.
- Staff adhered to uniform policy and followed bare below the elbow guidelines.
- We noted that some outpatient waiting areas had material covered chairs, which staff acknowledged were difficult to clean. The hospital was replacing all of these chairs as part of refurbishment upgrades in the coming year.

Environment and equipment

- Outpatient reception and waiting areas were bright, well furnished, decorated and appropriate for the service.
- Al rooms were spacious. Wide doors allowed ease of access for patients using wheelchairs and all rooms were fitted with an emergency call system.
- Staff completed informal daily checks and regular audits to ensure the environment was safe for patients. Results from PLACE and local environmental audits were good.
- The hospital had appropriate arrangements for the safe handling and disposal of clinical waste and sharps. In chemotherapy services, only trained staff were authorised to handle cytotoxic waste in accordance with local policy.
- All equipment on site met local and national safety regulations. There was evidence of electrical equipment testing and equipment was labelled accordingly. The hospital used a third party provider to check medical devices and they maintained equipment logs. The hospital provided medical devices training and staff attended the medical devices group, which formed part of the integrated governance framework.
- The hospital followed the British Society of Gastroenterology and Department of Health (DH) guidelines on decontamination and traceability for endoscopic equipment with on-site washing and processing facilities. Washing machines were checked in accordance with policy and staff completed weekly water testing to ensure appropriate disinfection was taking place.
- Resuscitation equipment including defibrillator, oxygen and suction was readily accessible and available in outpatients.
- Directions within the hospital were good. However, signage at the reception area on second floor outpatients was misleading for some patients who were confused by 'The Jesmond Clinic' branding for cosmetic and weight loss surgery when they had attended for out-patient appointments unrelated to these particular services.

- There were designated private gynaecological area, cardiac exercising facilities and ophthalmology rooms.
- Reception areas were open-plan and at times were not helpful if patients wished to raise concerns or discuss personal health or financial matters; however, private rooms for such discussions were available.
- Waiting areas were comfortable and spacious with plentiful seating. Hot and cold drink facilities were available and toilets were accessible. There was a designated children waiting and play area.

Diagnostic imaging

- The hospital provided a specific diagnostic imaging reception and waiting area, which was suitable for the services offered.
- There were separate waiting areas for those outsourced diagnostic imaging procedures namely MRI and CT.
- Private changing areas were available within the department however; there was no designated disabled toilet.
- The department displayed appropriate safety signage at door areas detailing radiation information, hazards and radiation protection supervisor (RPS) contact details. Restricted access areas were locked appropriately and signage clearly indicated if a room or scanner was in use.
- The hospital radiation protection adviser (RPA) approved the layout of the diagnostic imaging department and room specification to be safe and fit for purpose.
- Staff acknowledged some imaging equipment was aging however the equipment was capable of carrying out safe and efficient diagnostic imaging of sufficient diagnostic quality. The hospital should ensure there is a robust x-ray equipment capital replacement plan to ensure future reliability and quality.
- Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment. Each room held maintenance records for the respective piece of equipment. Equipment maintenance contracts were checked and records showed all schedules were up to date. The performance of all equipment was satisfactory.
- The department had all required mandatory policies and procedures in place in relation to the radiation protection principles and regulations covered by IRMER and IRR99.
- Staff felt they were provided with appropriate personal protective equipment to undertake their role safely.
- Resuscitation equipment including defibrillator, oxygen, and suction was readily available in diagnostic imaging.

Medicines

- Medicines including local anaesthetic and contrast media were supplied and audited by the pharmacy department through monthly audit, safety and secure storage checks and daily departmental visits.
- Medicines in the departments were stored in locked cupboards and monitored appropriately.
- Staff ensured medicines that required refrigeration were stored within safe temperature ranges. Fridge temperature checks were completed on a daily basis.
- No controlled drugs were stored on the departments.
- The hospital did not administer any radioactive medicines however worked in partnership with a neighbouring NHS trust to provide sentinel node services. The hospital complied with Administration of Radioactive Substances Advisory Committee (ARSAC) guidance on best practice in nuclear medicine.

Records

- The storage of medical records appeared on the hospital risk register due to insufficient storage space.
- The hospital used a third party company to store notes off-site that needed to be retained.
- Generally, a full set of medical records was not kept by the hospital unless the patient required admission or was a regular attender. The hospital recognised the difficulties associated with not keeping a full medical note on site for all patients and were working with their consultants to build a patient record upon referral. Cosmetic and oncology outpatients kept patient records securely for repeat attenders. Private referral letters remained the ownership of the respective consultants however more often this was shared with hospital staff to add to the hospital record.
- The hospital ensured a patient record was present ahead of the booked clinic. This included patient demographics and referral information. There was less than 1% of patients seen in clinics without relevant documentation and on these occasions, initial patient details were taken at reception with the consultant completing an initial clinical clerking record.
- The hospital was implementing an electronic patient record system to ensure all attendees had a single

electronic hospital record however; the go-live date had not been confirmed. Staff hoped this would ensure all patients had an on site set of Nuffield clinical records available at all times.

- We reviewed ten sets of patient records (including electronic records) across the outpatient and diagnostic imaging departments. We found these were of a good standard. They contained sufficient up to date information about patients including copy referral letters, medical and nursing notes and patient care pathways.
- At the time of inspection, we saw patient personal information and medical records managed safely and securely.
- Consultants with practising privileges were able to take their own records off-site in accordance with the Nuffield Health Information Risk Framework. No Nuffield records were allowed off-site.
- Diagnostic imaging referrals and requests were made on paper forms or by fax directly from referrers. Staff transferred this information onto an electronic patient administration system and reports followed electronically.
- Electronic and paper patient records within diagnostic imaging were checked. These were completed correctly, including imaging request forms, risk assessments, last menstrual period (LMP) checks and WHO checklists (a proforma used to minimise risk related to patients undergoing procedures), in line with local policy and recognised national guidance.
- The radiology manager completed an audit of WHO checklist completion in July 2015 where 64% fully complied with the standard. The audit was repeated in December 2015 and compliance was recorded at 100%.

Safeguarding

- The services reported no safeguarding concerns during 2015.
- The hospital matron was the designated lead for safeguarding and had completed level three safeguard training. Outpatient Manager and Radiology Manager had also completed level three training and were local leads in their areas.
- Staff were aware of the safeguarding policies and procedures and were able to demonstrate how to access them. Staff were aware of their roles and responsibilities in relation to safeguarding and could describe what types of concerns they would report and the process for doing so.
- The safeguarding policy also provided guidance for staff on female genital mutilation in accordance with FGM: Multi-agency practice guidelines, 2014 (revised publication April 2016: Multi-agency statutory guidance on female genital mutilation).
- Safeguarding training was captured through the mandatory training process.
- Compliance varied across services. 100% of service managers requiring level 3 safeguard training were compliant. In outpatients and diagnostic imaging, safeguard training was recorded at 82% and 100% for level 1 and 2 respectively. In pathology, level 1 training compliance was recorded at 80%.

Mandatory training

- Staff complied with mandatory training requirements by completing on-line modules and attending face-to-face training.
- Departmental managers advertised training dates within the department and these were also on the hospital intranet for reference. Managers ensured staff attended required mandatory training and staff were given protected time to complete necessary requirements.
- The hospital set a target of 85% compliance for all mandatory training elements, which included various topics such as incident reporting, deprivation of liberty safeguards (DoLS), IPC, manual handling and safeguarding. There was also specific mandatory training sessions for pathology and radiology staff.
- The compliance target of 85% was consistently met in 2015. At the time of our inspection and partway through the training calendar for 2016, there were eight non-compliances out of 25 in outpatients, five out of 16 in pathology and six out of 27 in radiology. Staff were scheduled to complete or attend those sessions not yet complied with and were on track to achieve target.
- Medical staff completed mandatory training at their employing NHS trust. There were assurance systems in place to ensure compliance. Managers advised that any failure to meet mandatory training requirements would potentially lead to a suspension in practising privileges.

Assessing and responding to patient risk

Good

Outpatients and diagnostic imaging

- Nuffield staff met all patients on arrival at the hospital.
- Qualified practitioners had the opportunity to meet all patients prior to any clinical procedure or consultation. Where concerns were apparent about a patient's condition, an appropriate member of staff was asked to attend.
- There was a care pathway for the management of patients who became clinically unwell in outpatients. This provided a structured proforma and clinical framework to manage changes in a patient's condition.
- Those patients who were repeat attenders for treatment were aligned to an appropriate care pathway such as 'oncology' or 'on-going treatments'. The care pathway recorded assessments of patient risk such as the management of intravenous cannula, nutritional assessment, patient handling concerns and pressure ulcer risk.
- The hospital had a system in place for escalation of care and patient transfer to local NHS hospitals should care needs change requiring additional clinical support.
- Specific patient risks associated with endoscopy and other diagnostic imaging procedures were considered in line with national guidance and statutory requirements.
- Whilst not administering radioactive substances for sentinel node biopsy (a procedure where radioactive liquid is injected near to lymph nodes to be later removed for microscopic examination - SLNB) procedures, the hospital was responsible for the subsequent surgical procedure that followed. The hospital had a joint written agreement and aligned system of work in place with the partner trust. The hospital strictly adhered to Administration of Radioactive Substances Advisory Committee (ARSAC) guidance in the management of radioactive material.
- The diagnostic imaging department complied with Royal College of Radiologist (RCR) standards for intravascular contrast administration. We viewed the hospital policy for such procedures and compliance with the nine standards.
- The diagnostic imaging department had developed a strong and effective working relationship with their external radiation protection adviser (RPA). The adviser was accessible at all times during normal working hours with an on-call service at all other times. There were three on-site radiation protection supervisors.
- The diagnostic imaging department used new national IRMER template document (versions dated 4/16 in force at the time of our inspection) which complied with all mandatory procedures. The identification of 'referrers' document was very comprehensive and current. This ensured only referrals came from authorised persons in accordance with IRMER and local employer procedures.
- Staff made thorough checks to ensure that women who were or may be pregnant always informed a member of staff before any procedure. The imaging request form provided a referrer declaration to confirm the possibility of pregnancy had been taken into account. This was signed by the referrer and the patient to confirm agreement. This was further checked on arrival into the department and whilst the policy documents do not refer to last menstrual period 28 day rule, it followed Department of Health guidance to complete the 'missed period' check.
- The same form did not provide a further space for the radiographer checker to sign to confirm the safety checks had been verified. The reliance upon 'ticks' as evidence the checks had been completed could be misinterpreted as poor handwriting or as a referrer annotation. The form did provide for a radiographer or radiologist signature to confirm compliance with IRMER however, the diagnostic imaging manager agreed a radiographer checker initialling the key identification and last menstrual period prompts would be less likely to lead to potential oversight. Local written procedures should clarify what annotation is required by operators and practitioners to satisfy correct checks have been made.
- The RPA audit completed in 2015 was reviewed along with the two non-compliance findings and associated action plans. All actions plans were completed in February 2016 and signed to confirm agreed compliance with IRMER requirements.
- The pathology department had agreements in place with a neighbouring NHS trust to provide laboratory services out of hours. This included second sample storage, support, and recycling of blood products.
- The pathology team had adopted national Institute of Biomedical Science (IBMS) standard operating procedures for personnel dealing with haemorrhage. These included transfusion guidance and emergency contact details.
- The hospital provided an on-site blood audit release system (BARS) to securely manage and store blood required for transfusion. Staff expressed some frustrations with the system functionality however, there

were clear and simple user guidance documents along with user prompts on screen to assist. The system allowed the urgent release of blood bags in emergencies.
- Pathology staff acknowledged the BARS system was aging and confirmed their involvement with a new software package 'bloodhound' currently in development to ensure it worked with existing hospital packages.

Nursing, allied health professional and care assistant staffing

- The outpatient department had a dedicated team of registered nurses, healthcare assistants, receptionists and administration staff who provided clinic cover 6 days a week, generally between 8am to 8pm, this varied to accommodate specific patient requests and consultant working arrangements.
- A full-time senior sister managed general outpatients. Three part-time staff nurses and three health care assistants supported staffing on the main outpatient floor. The service used no agency nurses and had regular bank staff to cover specialist clinics.
- Due to the specialist nature of a number of the outpatient clinics, the hospital had appointed lead nurses into oncology, chemotherapy services and cosmetic surgery.
- Nurse staffing levels in the hospital were informed by NICE guidance (SG1 – safe staffing for nursing in acute hospitals). In outpatients, the nurse manager worked within a weekly maximum hour allocation to cover the clinics. We reviewed nurse staffing rotas (from April and May) and found actual contracted hours to be less than the maximum allowed within the department, averaging in the region of 179 hours against 234 maximum. We also noted the regular use of nurse bank staff who were specialist nurses and previous Nuffield employees. The outpatient manager confirmed staff rostering was very fluid to meet the needs and demands of the consultants and clinic times hence the additional hours available within the nursing rota.
- The outpatient manager and the outpatient administrative manager met on a daily basis to discuss clinic arrangements. The patient administration system (PIMS) recorded patient numbers against booked clinics and the outpatient manager staffed accordingly based on professional experience, staff expertise and patient need.
- The outpatient manager confirmed there had never been any incidents where staffing had been compromised where escalation was required. Staff fully understood the variability in private clinic provision and were flexible in their working hours to accommodate. Staff informed us if they had concerns about staffing, this would be raised to the matron or the duty manager.
- Staff in the outpatients department confirmed workload to be variable depending upon the number of clinics and the number of patients attending. They confirmed peak-times to be midweek evenings however, they felt staffing was always appropriate to meet patient needs.
- Out-of-hours staff accessed an on-call senior manager, senior nurse or radiographer as required.
- There were low rates of sickness absence for registered nurses, allied professionals and care assistants across the services. Overall, figures reported less than 10% sickness for all groups however due to small staffing numbers; absence of one member of staff for example, could generate what appears to be a disproportionate percentage comparator.
- In outpatients, there had been no staff turnover during 2015. 85.5% of staff in outpatients had worked at the hospital in excess of 1 year.
- There were currently no advertised vacancies across outpatients and diagnostic imaging.
- Human resources confirmed 100% validation checks of staff required to comply with professional registration requirements.

Diagnostic Imaging

- The Diagnostic Imaging department staffing consisted of the radiology manager, three permanent part-time senior radiographers and a health care assistant. A receptionist and an appointments officer supported the department.
- The department also used three bank radiographers from local NHS trusts to support additional theatre lists and weekend working.
- Generally, the diagnostic imaging department mirrored outpatient clinic times however, staff were flexible to meet particular requests outside their core hours.
- Specialist radiologists attended to cover head and neck, breast, vascular, renal, gastrointestinal, musculoskeletal, neurological and gynaecological imaging.

Good

Outpatients and diagnostic imaging

- The diagnostic imaging service also covered pain management services and ultrasound guided biopsy services.
- There was a 24-hour on call system available 7 days a week.

Medical staffing

- All patients were referred to a named consultant or chose a consultant they wished to see. There were 231 clinicians with practising privileges at the hospital with most being employed in local NHS trusts. The Medical Advisory Committee (MAC) had oversight of arrangements for consultants.
- There was a registered medical officer (RMO) available 24 hours a day, 7 days a week who had experience of cross-specialism working. The RMO was trained in both adult and paediatric advanced life support (ALS/PALS) and provided cover to consultant's out-of-hours.
- The RMOs had completed the necessary Nuffield mandatory training and local induction on taking up post.
- The RMOs liaised with the named consultant on a daily basis and received formal care handover at the end of each day.

Major incident awareness and training

- The hospital had business continuity and major disaster plans. This detailed roles and responsibilities along with escalation procedures covering a number of potential internal incidents such as fire and flood.
- The policy also highlighted potential external incidents, which may affect service provision such as pandemic flu, adverse weather conditions and other local emergencies. Such eventualities were co-ordinated by the hospital disaster service committee.
- The hospital had an on-site emergency generator in the event of a failure of utilities.
- Staff we spoke with were aware of the policy and could describe the types of incidents, which would trigger deployment.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the effective domain due to limited robust evidence.

- Patient care was delivered following recognised national guidelines, collegiate standards and best practice recommendations.
- Staff considered the holistic wellbeing of patients, which included an assessment of pain and consideration of nutritional status.
- Staff were skilled and competent for their role. Many had additional specialist qualifications or were experts in a particular field, which reinforced the quality of the care being provided to the patient.
- There was evidence of multi-disciplinary team working internally, with external referrers and NHS colleagues.
- All staff completed mandatory training covering Mental Capacity Act and Deprivation of Liberty Safeguarding.

However,

- Patient outcome data was not formally captured in outpatients and diagnostic imaging due to the transient nature of this patient cohort. Additionally, patient outcome indicators were often reported elsewhere within other services provided by the hospital.
- Staff had limited access to private consultant referral records restricting full access to patient information. Staff were working more closely with consultants to obtain full copies of their records to assist with better communications.

Evidence-based care and treatment

- Staff provided care and treatment in line with evidence-based practice. Policies and procedures, assessment tools and care pathways followed national standards, met statutory requirements and aligned to guidelines such as the National Institute for Health and Care Excellence (NICE), Royal College standards and best practice recommendations.
- Staff confirmed care was provided solely according to patient need, in best interests and with their informed

consent. Discrimination on grounds of age, disability, gender, gender reassignment, race, religion or belief and sexual orientation was not a factor when considering care and treatment decisions.
- Staff and patients gave examples how technology and equipment had enhanced their care, for example using non-routine pieces of equipment and considering international clinical research opportunities with organisations outside the UK.
- The diagnostic imaging department used diagnostic reference levels (DRL) as required by IRMER and the majority were below the national DRL levels for diagnostic exposures.
- The diagnostic imaging department monitored and audited DRL as part of their annual radiation protection programme. The audit results from March 2016 recorded slightly raised DRLs in chest and pelvic exposures against national standards. The team were reviewing these findings with the radiation protection adviser and staff were reviewing exposures checking dose area product (DAP). A follow up audit was pending at the time of our inspection.
- All endoscopic procedures and sentinel node procedures were carried out in theatre in accordance with professional guidelines and in line with statutory requirements.

Pain relief

- Staff considered pain may be a consequence of various treatment options and surgical procedures and this was discussed at consultation.
- Staff recognised when a patient was exhibiting signs and symptoms associated with pain.
- Staff described how they offered support to patients who reported being in pain by way of an assessment of cause, a review of self-treatments tried and a discussion with the doctor to address within the consultation.
- Patients were offered local anaesthetic for minor procedures completed in outpatients.
- The diagnostic imaging department performed ultrasound guided injections to administer pain relief for certain medical conditions.

Nutrition and hydration

- The hospital provided hot and cold drinks to patients attending out-patients and diagnostic imaging.
- For patients who were repeat attenders undergoing regular treatment cycles or day case care, staff provided options of a hot or cold meal. Staff monitored patient's nutritional state at repeat visits within the care pathway documentation and accessed dietetic services for support where patient's needs required.
- Patients and family members were given access to the hospital restaurant.
- PLACE audit findings highlighted patient satisfaction of food quality to be 98%.

Patient outcomes

- As many patients were transient through outpatients and diagnostic imaging departments, patient outcomes were not formally collated.
- Staff informally monitored patient progress at follow-up in the outpatient department.
- Staff used patient feedback and satisfaction surveys to gain an understanding of outcomes from the patient perspective following their experience at Nuffield.
- The endoscopy service at the hospital was not accredited by the joint advisory group on GI endoscopy (JAG).

Competent staff

- All staff completed the hospital induction on commencing work with Nuffield.
- All staff had required qualifications validated prior to commencing work at the hospital and thereafter upon revalidation or re-registration.
- Mandatory training compliance was excellent across the services and all staff completed an annual appraisal, which detailed personal development plans and training needs.
- The identification of learning needs was a three-way process within the departments influenced by line manager recommendations, staff request and preference and required mandatory training for professional registration purposes.
- Staff were actively encouraged to source internal training via the Nuffield Health Learning Academy and external learning opportunities with linked local universities and NHS organisations.
- Many staff attended specialist training events in local NHS hospitals to strengthen their knowledge in their area of expertise. This was often facilitated when working with the visiting consultants and through links with local trusts.

Good

Outpatients and diagnostic imaging

- Staff with particular interest in a field were supported to develop in the area irrespective of grade or designation within the organisation. This recognised the value of all levels of clinical and non-clinical staff.
- Newly qualified members of staff or those moving into a specific area for the first time were required to complete a period of preceptorship where competencies were assessed.
- Staff in outpatients had training folders detailing training completed and competencies in a variety of topics such as medical device training, clinical procedures and life support.
- In diagnostic imaging, staff completed scope of practice competencies set for particular pieces of radiology equipment such as mammography and fluoroscopy. Staff also monitored compliance requirements associated with IRMER and IRR99 such as identification and pregnancy procedures.
- We reviewed competency files. These were detailed with evidence of on-going review and sign-off.
- Staff held training sessions and informal one to one sessions with individual staff members to look at clinical supervision, competence and revalidation.
- Staff stated that managers supported and encouraged staff through the revalidation process. There was information on the corporate intranet and reflective discussions took place during appraisal.
- Staff working in departments dealing with children had paediatric life support skills.
- Visiting consultants with practising privileges completed a scope of practice document with their primary appraiser. These were reviewed annually by the hospital to ensure patients were receiving care from a competent practitioner. It was the duty of the responsible consultant to advise when scope of practice had changed or had been restricted or suspended.
- The Medical Advisory Committee (MAC) granted and reviewed practising privileges.

Multidisciplinary working

- A range of clinical and non-clinical staff worked as a team in outpatients and diagnostic imaging departments.
- Staff in outpatients and diagnostic imaging liaised with ward staff, lead nurses, NHS teams, radiographers, physiotherapists, dieticians, psychologists and consultants.
- The hospital employed specialist nurses throughout outpatients and had lead practitioners in oncology care, breast care and cosmetic surgery.
- Many staff had developed their skills into areas of interest, which offered opportunity to work with internal and external specialists.
- Radiology staff checked with non-Nuffield service providers when a patient had undergone imaging elsewhere in order to avoid a repeat or unnecessary exposure and to compare any changes between images.
- The teams had strong working relationships with professional referrers and NHS colleagues, which supported efficient team working cross-organisations to improve timely on-going care for patients.

Seven-day services

- Outpatient and diagnostic imaging services were routinely available from Monday to Saturday.
- The hospital provided out-of-hour support in diagnostic imaging, senior nurse rotas and senior management cover.
- Staff in pathology provided telephone advice out-of-hours. There were arrangements with a neighbouring NHS trust for laboratory work outside office hours.

Access to information

- All staff had access to the Nuffield extranet to gain information relating to policies, procedures, clinical guidelines and e-learning modules.
- Some lead nurses and specialist practitioners maintained folders of evidence, key documents, clinical updates and where to source further information for use by staff. The radiation protection supervisor based in theatre with responsibility for sentinel node procedures kept an accessible file in the office for staff to refer to. This included the regulatory requirements, WHO checklist, probe checking procedures, specimen collection and general information on the procedure. The file also contained guidance in the event of an incident with contact numbers of key personnel.
- Staff had limited access to private consultant referrals however kept brief information to support patient transition through the service. Staff were working more closely with consultants to obtain full copies of their records to assist with better communications.

Good

Outpatients and diagnostic imaging

- Referrers could discuss more difficult cases directly with the staff concerned or the consultant in charge of the patient care.
- The hospital provided electronic access to diagnostic and pathology results.
- Where referrals were made privately to a named consultant then their private secretary ensured referrers were updated in a timely manner. Referrers could speak directly to the receiving consultant in the event of queries.
- Staff hoped the proposed move to electronic medical records would improve access to information generally throughout the hospital and would in turn assist in more timely communications to referrers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Staff completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training during induction and as part of their mandatory updates.
- Staff had an understanding of the principles underpinning MCA and DoLS guidance and were aware of the hospital policy.
- Staff had an awareness of particularly vulnerable patient groups where these procedures would be most relevant.
- Staff confirmed it was primarily the consultant's role in assessing capacity to consent however if staff had concerns about a patients ability to decide on treatment options then this would be highlighted to the consultant, the hospital safeguarding lead and the departmental manager.
- Staff confirmed it was of the upmost importance that patients were fully informed; they should be given the opportunity to ask questions and agree with proposed treatment options. Where this was not possible due to a lacking understanding, staff confirmed they would always act in the best interests of the patient.
- Diagnostic imaging staff reported consent to be a priority before any routine procedures were performed.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Patients were treated with respect, dignity and compassion. Patients described positive experiences at the hospital and would recommend the service to friends and family.
- Staff made real and genuine efforts to meet patient requests and engaged with patients in a friendly and caring manner.
- Patients were involved in discussions about care and were informed about treatment options. Investigation results were made available in a timely manner allowing care to progress without undue delay.
- Staff considered the holistic wellbeing of patients beyond physical ailment and prioritised care according to patient need.

Compassionate care

- We spoke with nine patients including family members about the care they received at the hospital. All were positive about the service they had received.
- Staff in outpatients and diagnostic imaging were described as "fantastic", "professional" and that "care was simply excellent".
- The hospital recorded family and friends test scores. Between July – December 2015, response rates varied from 34.8% to 65.5% however, patient's recommendation of the hospital was consistently above 90%. In March 2016, 100% of patients attending outpatients would be extremely likely to recommend the service to friends and family.
- We were provided with sight of the Nuffield patient satisfaction survey results. Between January – March 2016, the Newcastle upon Tyne hospital performed consistently better than the majority of other Nuffield hospitals.
- Patients were respected and privacy and dignity was maintained. Patients had access to private changing areas and all consulting rooms used signage to confirm if a room was 'in-use'. PLACE audit findings supported this with patients rating satisfaction with privacy, dignity and wellbeing to be 93%.
- We observed staff at all levels communicating with patients and their families in a respectful and considerate manner. One patient stated that she felt "like a person not a number".
- A number of patients commented how staff ensured all their particular requests were met. One patient

described how promptly staff responded to a request to use a non-routine piece of equipment as part of the care package. The equipment was not readily available but "staff ran around and got this for me".

- Staff took into account personal preferences, cultural and religious beliefs when delivering care.
- Some reception areas lacked privacy as booking desks were within immediate vicinity of waiting areas. Whilst no clinical information was discussed, it was possible to overhear some conversations. Staff confirmed that private rooms were available should any patient request additional privacy.
- The services routinely and proactively offered chaperones to patients, in line with hospital policy, in particular when intimate examinations were necessary or if patients were anxious or requested additional support.
- Staff confirmed they considered the holistic wellbeing of the patient and not just the underlying physical concern that led to attendance. Patients commented that staff conveyed information in a sensitive and reassuring manner allowing family members to be present as the patient wished. This was reinforced in the chemotherapy services patient satisfaction questionnaire results where 15 out of 15 documents reviewed unanimously confirmed the staff to be "courteous and sensitive".
- Staff introduced themselves to patients in a friendly manner and offered their first name. We observed some repeat patients were familiar with their designated nurse and had clearly built up a personal rapport.
- Where patients were required to complete admission documents, staff made themselves available to assist with any queries or concerns regarding the content.

Understanding and involvement of patients and those close to them

- We observed staff spending time listening to patient concerns and explaining proposed treatment options before proceeding. Staff reinforced discussions with clinical evidence and literature to inform patient consent.
- One patient commented how the consultant spent considerable time with her and her husband going through key research findings, treatment options and further investigatory considerations prior to commencing the agreed care pathway.
- Staff confirmed it to be of the upmost priority that patients be fully informed about proposed treatment plans, be offered additional appointments and requisite 'cooling off' time where required before consenting. It was added that no patient would undergo any test or procedure without being fully informed, supported and aware of the risks, intended benefits and any cost implications.
- Staff encouraged patients to attend with relatives for support and subject to patient agreement; they could be involved in any clinical discussions.
- A number of patients who were repeat attenders commented that they were able to call into the department to receive blood results with many of them having direct access to their lead nurses and consultants as required.
- One patient commented that blood tests and investigation results were readily available immediately and this had reduced her anxiety in waiting for the formal appointment to discuss further. Staff allowed many of their known patients to contact the departments directly for telephone advice, guidance, support and to address any concerns they had.
- Staff dealt with discussions regarding payment outside the clinical sessions and in the majority of cases, before attendance. Staff stated discussions of this nature tended to be dealt with in private however, one patient informed us of a costs discussion-taking place at the reception bookings desk, which she found a little uncomfortable.
- All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about the care and treatment they could have. They all confirmed they felt informed and involved in their care and were given time to make decisions. They also stated that staff made sure they understood the treatment options available to them.

Emotional support

- Staff spoke with compassion and genuine warmth about their patients and described a real togetherness in meeting their needs.
- Staff, especially those in specialist oncology and cosmetic clinics, had a real understanding of the impact that care and treatment options had on their patients physical wellbeing, emotional status and personal relationships.

Good

Outpatients and diagnostic imaging

- Patients were given whatever time necessary to come to terms with both good and bad news during clinic appointments.
- A number of patients commented that they would not have got through the medical or surgical treatment if it wasn't for the emotional support provided by the staff. One patient commented that she knew the staff had many patients to care for, however "they always focus solely on me" when I need their assistance "day or night"
- Staff acknowledged that on many occasions, emotional need was often a greater priority to the patient's physical condition and they had sought professional psychological input where required. One patient informed us that staff suggested she may benefit from the professional support of a psychotherapist and she was duly signposted. She confirmed this to have had a real positive impact on her care and quality of life.
- Staff were empowered to make a difference to the emotional wellbeing of those they cared for and from patient comments about support outside clinic appointments, staff set up a coffee morning. This allowed current and previous patients to come together with family members at an informal gathering where they could access the wellbeing team, engage with others and take advantage of communal support.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Service planning was solely aimed to meet patient need, with specialist practitioners available at times to meet individual requests.
- The hospital reported very good referral to treatment times for 18 week targets ensuring patients received access to treatment in a timely way.
- Investigation turnaround times in diagnostic imaging and pathology were good allowing patients to be appraised of results promptly so that care could be progressed without undue delay.
- Reasonable adjustments were made to accommodate vulnerable patient groups to improve their flow through the care pathway minimising anxiety and distress.
- The hospital process for handling, investigating and responding to patient concerns and complaints was sensitive, compassionate and organised to resolve matters promptly to the satisfaction of all parties.

However

- Clinic waiting times were not displayed and the process of informing the patients of real or potential delays was variable which may affect overall patient satisfaction. However, staff did inform patients of any potential delays.
- There was a lack of a formal structure to meet the needs of patients who required additional support due particular special needs or learning difficulties.

Service planning and delivery to meet the needs of local people

- The hospital provided independent healthcare for self-funded and NHS referred patients. All patients, from whatever referral source, were offered a choice of preferred consultant, an appointment time to suit and for self-funding patients, options on payments methods.
- The hospital management team had strong links with the independent sector and insurers. The hospital engaged with local NHS trusts and local clinical commissioning groups (CCG) to plan and deliver contracted services based on local requirements. Staff at all levels had developed good working relationships with local NHS and CCG peers. There were various work streams and referrals from these sources.
- To take pressure away from hospital switchboard services, the hospital provided direct and dedicated telephone access to the service centre for patient booking enquiries. There was also a dedicated enquiry line for consultants and their private secretaries.
- The hospital had service level agreements with external diagnostic imaging providers contracted to carry out magnetic resonance imaging (MRI) and computerised tomography (CT).

Access and flow

- There was a range of outpatient clinics offered in over 20 specialities including a variety of surgical specialties, cosmetics, dermatology, gynaecology, neurology and oncology.
- The hospital built appointment times around patient need such as the nature of the referral, request for a

particular consultant, urgency of request and preferred time slot. The hospital did not formally collate appointment waiting times as clinics could be set up and arranged within 24 hours where required.

- Patients were offered appointments quickly at pre-booked clinics or where such clinics had not been formally diarised; these could be set up in agreement with the requested consultant within 24 hours. All appointment and waiting times met the required standards.
- From initial enquiry, clinic allocation, through first attendance and onward care continuity, the service prided itself on being flexible to meet patient requests. This included choose and book requests (NHS e-referral system).
- Patients were provided with full information regarding their appointment at the time of the initial telephone enquiry and the same was followed up an appointment letter detailing location, directions, consultant information, specific requirements for the appointment and providing contact details.
- Overall, clinics were arranged to suit patient request and this included out-of-hours, evenings and weekends.
- The hospital allocated appointments based on clinical need and not ability to pay. All patients received their consultation and access to treatment options quickly. Staff confirmed there was no cap on appointment numbers and no minimum number of patients required for a clinic to run. This allowed patients to access clinic in a timely manner and avoided cancellations.
- In 2015, there were 24,990 outpatient attendances, 11,902 were first attenders and 13,088 were follow up visits.
- There were 3,395 NHS funded patients (960 first appointment and 2435 follow up) and 21,595 were classified as 'other funded' (10,942 first attenders and 10,653 follow-up). Children under 16 accounted for 423 (3.5%) first appointments and 288 (2.2%) follow-up appointments.
- The three specialisms with the greatest number of attendees were in orthopaedics (7,833), cosmetic surgery (2,436) and general surgery (2,276).
- The hospital was consistently better than the national referral to treatment (RTT) waiting time target of 92% for incomplete admitted patients beginning treatment within 18 weeks of referral averaging 96.2% throughout 2015.
- The hospital was better than the national RTT waiting times target of 95% for non-admitted patients beginning treatment within 18 weeks of referral between January to May 2015 averaging 97.1% (the targets for this indicator were abolished in June 2015).
- The hospital did not formally audit 'did not attend' (DNA) or clinic cancellation rates however we were assured that processes were in place to follow up patients who DNA and to offer alternative care provision when a clinic was cancelled. During the inspection, there were no DNA and no clinic cancellations.
- The hospital did not formally advertise waiting times in waiting areas however; reception and nursing staff monitored these remotely. Staff confirmed if patients waited beyond their designated appointment slot, staff would apologise for any delay, explain the reasons for the same and provide a more accurate timing. If appointment waits exceeded 15 minutes, nursing staff intervened to identify the factors causing extended waiting periods. During the inspection, we observed no delays in any of the clinics or waiting times for diagnostic imaging procedures.
- There was capacity within the departments to see patients and carry out diagnostic imaging on the same day when required however average turnaround times for diagnostic imaging appointments was generally less than a week. Staff aimed to turnaround all radiology reports within five days. In 2015, the turnaround time audit in diagnostic imaging confirmed 97% of all diagnostic imaging was reported within the five-day benchmark.
- Pathology services recorded performance and turnaround times against Nuffield benchmarking and national accreditation standards. In March 2016, routine turnaround time for selected pathology tests performed in the hospital showed 98% and 93% for standard biochemistry and haematology specimens accordingly. Overall, the hospital reported 94% compliance on turnaround times for all selected tests.

Meeting people's individual needs

- Staff ensured all patient preferences and particular needs were considered as part of their care package.
- Staff recognised certain patients might require additional support in advance of attending the hospital and during the appointment such as children or those with disabilities.

Good

Outpatients and diagnostic imaging

- Reasonable adjustments were made to support potentially vulnerable groups such as those living with dementia or those who have learning disabilities. Patients were offered pre-visits, flexible appointment times, queue bypassing, the provision of private waiting areas and the option to have a carer or family member with them throughout. There was no formal structure to address the needs of this particular cohort of patients however staff advised they responded on an individual basis.
- Where potential communication difficulties were anticipated, often highlighted at the initial booking stage, staff confirmed they would arrange interpreters or other communication support options where required.
- The hospital dementia rating in the PLACE audit was slightly lower than England average (77% compared to 81%). The matron explained this was due to some shortfall in dementia friendly environmental indicators such as signage and flooring. The hospital was reviewing these findings to see what reasonable adjustments could be made to the environment to improve care for these patients.
- Staff in radiology endeavoured to accommodate patient's on the same day to avoid the potential distress and inconvenience caused by a repeat visit.
- Transport support was provided for those with mobility issues or who had bariatric requirements.
- Clinics had audio induction loop systems to assist those with hearing difficulties.
- Literature was available within all waiting areas and we were informed, although not on display at the time of our visit, large print and alternative language leaflets were available.
- There was no on-site facility to engage in religious activity.
- The hospital provided free parking on-site however due to limited spaces; the hospital had purchased parking permits so staff could park in the adjacent streets and neighbouring businesses to free up space within the hospital. Public transport links were very good with public bus and train services within a short walk from the hospital.

Learning from complaints and concerns

- The hospital had a complaints policy, which was approved in November 2014.
- The hospital advertised complaints information for patients and provided a booklet entitled 'how to make a comment or formal complaint'. These were situated in all waiting areas.
- The hospital received 31 complaints in 2015, an increase from 2014. Four (12.9%) of these were aligned to the outpatients and diagnostic imaging service although three were related to patients being misinformed about treatment costs by consultants.
- The hospital director was responsible for the management of complaints, supported by matron and relevant clinical heads of department (CHoDs) when concerns were of a clinical nature. Complaints relating to individual consultants with practising privileges involved the Medical Advisory Committee (MAC).
- The hospital acknowledged complaints immediately by letter and initially discussed these within the senior management team (SMT). We reviewed minutes of CHoDs meetings and integrated governance minutes where complaints were discussed.
- The SMT appointed an investigation lead to look into the concerns raised and a full written response was provided to the complainant within 20 working days.
- We reviewed five complaint files. In all cases, an acknowledgement letter was sent on the day the complaint was made, details of the investigating officer, response timetable was noted on the file, and deadlines were met. The response letter to the complainant was polite and apologetic and addressed patient concerns with remedy where relevant. Complaint responses were followed up to ensure all concerns were addressed satisfactorily and there was evidence from complaints expressing their satisfaction with the conclusion.
- Staff described how they always endeavoured to resolve patient concerns informally in the first instance, but would escalate to senior staff if necessary. Staff were aware of the hospital policy.
- Departments discussed outcomes from complaint investigations to learn lessons and improve patient care. We were informed and saw evidence of changes in practice following outcomes of complaint investigations such as improved departmental communications, changes to processes for the costing of treatment and a change in third party provider.

Are outpatients and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging

Good

We rated well led as good because:

- There was a clear vision and strategy for the service.
- There was an integrated governance framework with evidence of risk, quality and performance discussed at senior levels within the service.
- Radiation regulation within diagnostic imaging was well-established with thorough and robust procedures in place.
- An experienced, visible and approachable leadership team supported staff.
- There was a strong emphasis on openness and honesty within a 'team culture' where staff positively commented on their working environment.
- A desire to understand the patient experience to improve the service and to keep staff informed of the organisation plans was evident.
- Improvement projects and innovations were patient centred with the overall aim to improve patient care and the quality of the service.

However,

- Some room radiation risk assessments in diagnostic imaging were generic and lacked detail.

Vision and strategy for this this core service

- Nuffield Health had a clear vision. Managers confirmed staff influenced the development of the hospital vision and beliefs from feedback at focus groups.
- Managers acknowledged the importance of the commercial aspect of the business and the Nuffield 'brand'. Staff saw this as a positive component in providing quality patient care by building strong internal and external working partnerships, in particular, with neighbouring NHS trusts.
- Departmental managers adopted the organisational values, beliefs, and staff talked about "being EPIC" (enterprising, passionate, independent and caring), "One Nuffield" and the "Love for Life".
- Staff felt the organisational values represented what they were trying to achieve in their departments. Staff confirmed the values and beliefs were embedded within their departments forming the framework for personal development plans and appraisals.
- Staff told us the hospital shared their vision on plans and proposals for the development of the departments through regular updates.

Governance, risk management and quality measurement for this core service

- The hospital had an integrated governance framework to support the delivery of their objectives.
- The governance structure supported hospital aims to deliver clinical excellence and patient satisfaction.
- We reviewed hospital board, CHoDs, MAC and governance group minutes. All considered key governance factors such as safety, quality, performance and finances.
- All consultants with practising privileges registered with the hospital adhered to the practising privileges policy and provided the hospital with evidence confirming they met policy criteria.
- In diagnostic imaging, the additional risk considerations from radiation regulations were managed in partnership with the external radiation protection adviser/medical physics expert (RPA/MPE). The hospital RPA/MPE had worked with the hospital for almost 20 years, had detailed knowledge of the site and had built up strong working relationships with the hospital. Risk assessments were reviewed annually in conjunction with local radiation protection supervisor (RPS) support locally along with audit and equipment surveys six-monthly.
- There was an alignment between recorded risks and what departmental managers identified to be their areas of greatest concern. Departmental risk registers were current and detailed risk level clearly. Some room risk assessments in diagnostic imaging were generic and lacked sufficient detail. There was a responsible 'handler' attached to each risk and evidence of on-going review.
- There were various assurance systems and service measures in place to monitor compliance and performance. The hospital produced monthly quality and safety dashboard data. Between December 2015 and February 2016, all domain indicators covering safety thermometer variables, readmission rates, patient satisfaction data and departmental key performance indicators were all within expected limits.
- There was a calendar of audit activity within departments to monitor quality and to provide two-way feedback between SMT and CHoDs.

Good

Outpatients and diagnostic imaging

- The hospital manager through the MAC and human resources ensured any consultant seeking practising privileges had appropriate and valid professional indemnity insurance in accordance with the Indemnity Arrangements Order 2014. Additionally, the hospital requested sight of relevant appraisal documentation from the consultant's main employing organisation about performance against national standards. The hospital also completed its own internal appraisal for sharing with the primary appraiser.
- Staff carried out similar assurance checks when a consultant requested to use a member of their own staff to assist with their practice. This included verification of qualifications, registrations and insurances were appropriate.
- The roles and responsibilities of the MAC were well defined and there was good engagement in governance oversight, particularly around reviewing practising privileges and advising on consultant performance.
- The hospital worked with consultants to ensure a clinical record was maintained following every attendance and kept on site for ease of reference. The hospital planned to move to a single electronic clinical patient record. This was currently being piloted and developed with Nuffield.

Leadership of the service

- The hospital had an experienced senior management team with relevant clinical (NHS and independent) and associated industry background suitable to their roles.
- Staff expressed there was a great deal of respect for one another and commented very positively about the support and commitment of their managers.
- Staff and mangers themselves were confident they had the necessary skills, knowledge, experience and integrity to manage departments and support the organisation.
- Managers confirmed they were encouraged to reflect upon their own leadership styles to identify areas for development. The SMT and the Nuffield Health Academy supported staff to develop leadership skills.
- Managers considered themselves to be approachable and "part of the team". Staff agreed that managers could be contacted at any time and encouraged interaction.
- Departmental managers acknowledged the demands of their role in meeting hospital targets and organisational needs. Departmental managers supported each other by way of formal and informal peer support, at CHoDs meeting and through wider Nuffield networks.
- Staff at all levels commented, on the support offered by the hospital matron.

Culture within the service

- Staff felt respected and valued.
- The hospital value to "be straight with people" and "tell the truth" was a belief staff felt gave strength to their teams. This was reinforced when dealing with issues within the teams where staff explained they "pulled together" to resolve matters that hindered the achievement of quality.
- Staff knew how to deal with conflict and such issues were referred to managers.
- Staff were aware of their whistleblowing policy, there had been no concerns reported.
- Staff stated the organisation was "passionate about care" and did whatever it took to meet patient needs.
- There was a clear team approach within the departments. Staff of all grades and at all levels were actively encouraged to engage in the wider agenda. We observed teams across all departments working well together.
- Staff who expressed a particular interest in a chosen field were supported to enhance their knowledge and skills in that area. This led to some unqualified members of staff extending their roles and taking on additional responsibility under supervision to contribute to hospital and departmental projects.
- The roles and responsibilities of key personnel were well defined and staff we spoke with understood the importance of cascading relevant managerial discussions and decisions into the relevant departments. Staff told us minutes from these meetings were available to them and headlines fed back at staff meetings.
- The hospital recognised the excellent work staff delivered and had shown their appreciation by holding staff social events funded by the organisation. Additionally, staff accessed Nuffield Health gyms and the wellbeing team to support good health.
- Staff felt proud working for the organisation and were happy to come to work.
- There was low staff sickness and staff turnover rates.

Good

Outpatients and diagnostic imaging

Public engagement

- The hospital actively encouraged patients to complete a satisfaction survey during or after their visits. Feedback from surveys was considered at national, local and departmental level.
- Departments had devised their own supplementary patient satisfaction questionnaires specific to the services they provided. In chemotherapy services, patients commented favourably about their experience.
- Following patient feedback, staff in oncology outpatients set up a coffee morning for patient peer support. This patient led agenda had seen involvement of the Nuffield wellbeing team who had provided lifestyle support.
- The hospital held patient forums as another means to engage patients and their families. Attendance at these events was generally low and the hospital were proactively looking at other options to engage patients such as social media and using technology.

Staff engagement

- Staff informed us they were invited to provide comments for the development of the hospital strategy and vision.
- Staff felt they had a voice within their department and considered their views and opinions to be listened to and respected by managers.
- Staff were actively engaged in the planning and delivery of services and in shaping the culture of the organisation. A number of staff suggestions had brought about changes in the workplace such as the development of standardised documentation and care pathways.
- Staff at all levels were comfortable in raising concerns directly with their line managers and in group settings. Staff stated their managers responded proactively to concerns.
- The hospital engaged with their employees through a quarterly staff survey called 'Leadership MOT' (LMOT). This was a survey, which captured staff opinion on a variety of key indicators related to the working environment. The results of the survey were benchmarked against other Nuffield sites. In October 2015, out of the 13 indicators, overall the hospital scored better than other Nuffield hospitals in 12 and equal in one. In diagnostic imaging, findings were consistently better in all categories however, in outpatients only seven of the 13 categories were better than the Nuffield benchmark.
- The matron informed us that the lower scores in outpatients were due to staff in administrative services retiring or going on maternity leave, which left a shortfall until new staff were appointed, and there was also some uncertainty because the department was going through a restructure. Since the October LMOT, improvements had been made with changes to the reception area, customer call centre and recruitment of staff.
- Staff contributed to and received bulletins, emails and newsletters about hospital and departmental activities, patient comments and clinical updates.
- The Nuffield Health Academy engaged with staff for professional development, clinical training and courses. Staff felt supported during revalidation requirements.

Innovation, improvement and sustainability

- A member of staff in the outpatient department developed IPC literature for children relating to the importance of handwashing. These included stories, educational material and play related learning activities.
- In oncology outpatients, the lead nurse adapted a regional network policy for the benefit of patients receiving chemotherapy who may require telephone advice and triage (assessment of clinical need) out-of-hours.
- Following patient feedback, staff in oncology outpatients set up a coffee morning for patient peer support. This patient led agenda had seen involvement of the Nuffield wellbeing team who had provided lifestyle support.
- Staff in outpatients and diagnostic imaging developed their own patient satisfaction surveys to get feedback specific to their clinical areas to improve the patient experience.
- In breast care services, the lead nurse provided areola micropigmentation (colouring of the breast to develop a nipple feature) and this was exceptionally well received by patients. The service had developed and provision was being made to work with local NHS providers to reduce their waiting lists for this procedure.
- Where helpful to rehabilitation and recovery, staff in outpatients offered patients free passes to Nuffield gym facilities.

Good

Outpatients and diagnostic imaging

- In diagnostic imaging, to improve the service for patients, staff provided an appointment reminder by telephone on the day before the procedure.
- Where a child was attending for an imaging procedure, staff liaised with the child's parent or guardian to offer a pre-procedure visit. Additionally, staff offered suggestions to parents on how to 'role-play' the procedure at home prior to the visit to reduce anxiety and distress caused by the unfamiliarity.

Outstanding practice and areas for improvement

Outstanding practice

- At pre-assessment, the provider had access to information held by community services, including GPs. GPs were asked for faxed summary sheets which provided the hospital with details of the patient's medical history and medications.
- The development of breast services to include areola micropigmentation had brought about positive outcomes for patients. Local referrers recognised this and the service had been extended to reduce NHS waiting times.
- In oncology outpatients, the lead nurse adapted a regional network policy for the benefit of patients receiving chemotherapy who may require telephone advice and triage (assessment of clinical need) out-of-hours.
- Departmental initiatives to support children attending outpatients or diagnostic imaging were innovative with infection prevention education and try at home 'role-play' exercises to reduce anxiety and distress.
- The hospital worked closely with the local Jehovah witness hospital liaison group, who provided staff training, information leaflets such as what to do prior to surgery and alternatives to transfusion.

Areas for improvement

Action the provider SHOULD take to improve

- Ensure that processes for evidencing changes to a consultant's scope of practice are strengthened between the independent hospital and NHS trust rather than solely relying on a clinician's self-declaration.
- Ensure that staff follow best practice guidance post operatively (for example, anaesthetists to wait until a patient leaves the recovery area even though the patient maybe awake and well).
- Continue to address the storage issues in theatres and on some wards.
- Continue to improve the environment where reasonable to ensure it is appropriate for patients with dementia.
- Review the room risk assessments in radiology, which were generic and lacked specific detail.
- Local written procedures in radiology should clarify what annotation is required by operators and practitioners to satisfy correct safety checks have been made.
- The hospital should ensure there is a robust x-ray equipment capital replacement plan to ensure future reliability and quality.
- To display clinic-waiting times to ensure patients are fully informed of any delays.
- Consider the provision of a disabled access toilet in diagnostic imaging.
- Consider putting a formal process in place to support those patients with learning difficulties or special needs.
- Ensure a clinical record of the patient consultation is kept on-site for ease of reference should the need arise.
- Revisit the patient journey in outpatients regarding confidentiality at reception desks, conflicting signage in outpatients and the Jesmond Clinic.
- Progress refurbishment plans for the replacement of maternal chairs to alternatives, which can be easily cleaned.