Tees Valley Treatment Centre

Quality Report

One Life
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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

Overall summary

Tees Valley Treatment Centre (TVTC) is operated by Ramsay Health Care UK Operations. We carried out an announced, comprehensive inspection of the hospital on 17th and 18th January 2017, along with an unannounced visit on 30th January 2017, as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical and outpatients services, as these incorporated the activity undertaken by the provider at this location.

The hospital/service used a shared building in the centre of Middlesbrough and provided services to patients across north and south Tees and surrounding areas. It was a modern facility for day case surgical, diagnostic procedures, and outpatient services. The centre was commissioned locally to provide elective orthopaedic, general surgery, endoscopy, plastics, urology, gynaecology, and oral surgery services. From October 2015 to September 2016, the service reported 6,958 day

Summary of findings

case attendances. The endoscopy service was accredited by the Joint Advisory Group (JAG) for Gastrointestinal Endoscopy in February 2014, recognising standards and quality in endoscopy services. The outpatient department hosted specialities such as gastroenterology, general surgery, orthopaedic surgery, and plastic surgery. From October 2015 to September 2016 the hospital outpatient department recorded 19,730 total outpatient attendances. Of these, 8,918 were new appointments and 10,812 were follow-up appointments.

The hospital did not have overnight beds and did not admit emergency patients. It did not provide services for children and young people between the age of 0 and 18 years. TVTC had contract agreements for radiology, pathology, histopathology, blood transfusion, critical care and non-critical transfer, physiotherapy, and sterile services. The hospital was open from 7:30am to 8pm Monday to Friday, with additional capacity for Saturday working. Facilities included a pre-assessment area, two operating theatres, and an eight bedded recovery area (made up of two stage one recovery bays and six stage two recovery bays). There were three private outpatient clinic rooms. Of the surgical and outpatient activity delivered, 98% was NHS-funded with the remainder being funded via medical insurance or self-pay.

There were 13 nurses, eight health care assistants and three operating department practitioners, with 18 support and administrative staff. The hospital employed three doctors, and 43 consultants worked with practising privileges at this hospital. The senior leadership team comprised the general manager, matron and finance manager. The hospital was supported by experts in the Ramsay Health Care UK group and externally from local NHS providers.

To get to the heart of patients' experiences of care and treatment we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Prior to inspection we reviewed a range of performance information about the hospital. We spoke with 33 members of staff; we reviewed 17 healthcare records and spoke with 14 patients. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Overall we rated TVTC as good. We rated it good for being safe, effective, caring, responsive, and well-led in surgical and outpatient services because:

- All patients we spoke with told us they were treated courteously and respectfully and their privacy was maintained. There was a strong, visible patient-centred culture within the organisation and embraced by all staff. Staff considered holistic, quality patient care paramount to service delivery. Staff recognised the totality of patient need and there were examples where staff had gone the extra mile to meet this. Feedback from patients using the service was consistently positive and collected in a number of approaches.
- The leadership, governance, and culture within the service were very good. There was a consistency in the vision, strategy, and culture of the organisation which was embraced by all staff. Governance arrangements were reviewed, adaptable to change, and reflected best practice. Managers were focused on delivering quality care and improving patient outcomes. Managers acknowledged the importance of their teams and recognised the value of their input into service provision. Managers were visible, approachable, available at all times, and were open and honest. Staff were proud to work for the organisation and morale was valued. The security of funding to build a new hospital had ignited a new energy and positivity throughout the service. The leaders of the organisation listened to staff and actively supported staff creativity and staff initiatives.
- There were robust incident reporting systems in place and we saw incidents were fully investigated and lessons learnt were shared with staff. Staff reported incidents confidently and there was a good track record on safety related issues.

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- Infection prevention and control practices were good, and departments were clean and well-equipped. Record keeping, in particular for risk assessments and safety checks, was very good. Local policy for medicines management followed recognised guidelines.
- Staffing levels were planned and monitored to keep patients safe at all times. Staffing levels across departments were good. There were good processes in place to monitor signs of deteriorating health and respond to medical emergencies. Overall, mandatory training figures were good and attendance was well-managed. Staff had an awareness of safeguarding procedures and where to refer for additional support and guidance.
- Patient care and treatment was planned and delivered in line with current evidence-based guidance, standards, and best-practice recommendations. Outcomes for patients were good. Patients confirmed pain relief and nutritional standards met their needs. The service had maintained Joint Advisory Group (JAG) in Gastrointestinal Endoscopy accreditation since 2014.
- Staff received annual appraisals, were supported with revalidation, and worked together proactively to ensure best care and treatment was delivered to patients. Consent to care and treatment processes were good and patients were able to make informed decisions.
- TVTC planned and developed services to meet the needs of the local people which included flexibility and choice. Care and treatment was coordinated with other allied medical services. Referral to treatment times were consistently good. The service made reasonable adjustments to support vulnerable patient groups. Managers proactively monitored flow (waiting times, delays and cancellations) and kept patients informed accordingly. Service complaints were low and staff responded to these in a timely manner.

There were no breaches of regulations. However there were areas where the provider should make some improvements. These were:

- The hospital met the ethos of duty of candour in terms of apologising to patients and providing an explanation but did not strictly meet the group policy requirements or the full legal process, specifically in terms of meeting 10 day timescales to respond in writing to patients.
- The provider should continue with audit and improvement work to improve staff compliance and consistency of completion of National Early Warning Score (NEWS).
- The provider should develop the local and corporate risk register to ensure all clinical and local risks to service are captured fully.
- The provider should continue to monitor the attendance of theatre staff at mandatory training to ensure the action plan is fulfilled and compliance is met for 2016/2017.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients. We rated this service as good in safe, effective, caring, responsive and well-led.
Outpatients and diagnostic imaging	Good	Outpatients services were proportionate to the hospital surgical activity and significant activity was managed with three clinic rooms. Diagnostic imaging was not provided as an outpatient service. Some diagnostic x-ray testing was carried out during orthopaedic limb surgery by qualified consultants. The arrangements for this were good. We rated the service good for safe, caring and responsive and well-led. We inspected but do not currently rate effective.

Summary of findings

Contents

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Tees Valley Treatment Centre

Services we looked at
Surgery; Outpatients and diagnostic imaging;

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Background to Tees Valley Treatment Centre

Tees Valley Treatment Centre (TVTC) was operated by Ramsay Health Care UK Operations. The hospital/service opened in 2007. It was a private day-care hospital, operating Monday to Saturday from 7:30am until 8:30pm with no overnight stay beds. It shared an NHS building in central Middlesbrough, Cleveland. The hospital primarily served the community of Teesside. It also accepted patient referrals from outside this area. It was a modern facility for day-case surgical, diagnostic procedures and outpatient services.

The hospital had a registered manager in post from 2007 and the hospital director had been in post since 2014. The senior leadership team had been stable over this time period. There had been no previous reported compliance actions associated with this location and services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, an assistant inspector and specialist advisors with expertise in governance, surgery, outpatient, theatre management, nursing and medicine. The inspection team was overseen by Sandra Sutton, Inspection Manager.

Information about Tees Valley Treatment Centre

The day case hospital was open from 7.30am to 8.30pm Monday to Saturday. Facilities included a mixed-gender pre-assessment area, two operating theatres, and an eight-bedded recovery area, (made up of two stage one recovery bays and six stage two recovery bays). There were three private outpatient clinic rooms on the ground floor of the building with waiting areas. There was no facility for overnight stay or emergency admissions to the hospital.

Almost all of the surgical and outpatient activity delivered is NHS funded care with the remainder (2%) being medical insurance or self-pay. Outpatients covers the following specialities; gastroenterology, general surgery, orthopaedic surgery and plastic surgery. From October 2015 to September 2016 the hospital outpatient department recorded 19,730 total outpatient attendances. Of these, 8,918 were new appointments and 10,812 were follow-up appointments. 6958 surgical procedures were performed in the same time period and included elective orthopaedic, general surgery, endoscopy, plastics, urology, gynaecology, cosmetic surgery and oral surgery services. The endoscopy service was accredited by the Joint Advisory Group (JAG) for Gastrointestinal Endoscopy in February 2014 recognising standards and quality in endoscopy services.

Tees Valley Treatment Centre (TVTC) was registered to provide the following regulated activities:

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

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

During the inspection, we visited the pre-assessment area, recovery bays, both theatres, three clinic rooms and waiting areas. We spoke with 33 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 14 patients. During our

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inspection, we reviewed 17 sets of patient records. We held focus groups with staff to allow them time to talk to inspectors and share their experiences of working in TVTC. We also interviewed the members of the management team, the chair of the Medical Advisory Committee (MAC) and the lead pharmacist for Ramsay Health Care UK on site. We reviewed all complaints from 2016/17. We reviewed 10 practising privileges consultant personnel files.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital/service had been inspected in 2013. This was the hospital's first comprehensive inspection since the introduction of the new CQC methodology. In October 2013 we found that the hospital was meeting all the standards of quality and safety it was inspected against.

Activity (October 2015 to September 2016)

- In the reporting period October 2015 to September 2016 there were 6,958 day case episodes of care recorded at The Hospital; of these 98% were NHS-funded and 2% other funded. The most common procedures were reported as: Minor Skin Surgery (2232); Diagnostic Endoscopy (1432); Diagnostic Colonoscopy (872); Flexible Sigmoidoscopy (637); and Dental Procedures (571).
- There were 19,730 outpatient total attendances in the reporting period; of these 8,918 were new appointments and 10,812 were follow-up appointments. Of these appointments 1% were other funded and 99% were NHS-funded.
- There were 43 surgeons or anaesthetists working at the hospital under practising privileges. Three medical staff were employed permanently at the hospital. There were 13 employed registered nurses, eight care assistants, three operating department practitioners (ODPs) and 18 administrative and support staff, as well as having access to bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety in the 12 months prior to our inspection:

There had been one never event, in December 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The incident related to a dental 'wrong tooth' extraction. The matter was appropriately reported to the patient, an apology was made, and the local clinical commissioning group (CCG) was promptly informed. The incident was investigated thoroughly by senior managers and lessons shared with staff through meetings.

There had been one serious incident (SI) reported in the period from October 2015 to September 2016. There had been a thorough investigation of a readmitted patient who suffered post-operative complications caused by infection. There was evidence of lessons learnt and sharing information with the patient and team. This incident had triggered the duty of candour and a written apology was given to the patient.

There had been a total of 45 clinical and 11 non-clinical incidents reported from October 2015 to September 2016 attributed to surgery, outpatients and other reasons. Surgical services accounted for 29 clinical and 6 non-clinical, outpatients reported two clinical and three non-clinical. This is a low reporting rate compared to other independent hospitals.

There had been no incidences of hospital acquired Methicillin-resistant Staphylococcus Aureus (MRSA) and no incidences of hospital acquired Methicillin-sensitive Staphylococcus Aureus (MSSA). There had been no incidences of hospital acquired Clostridium Difficile (C.Diff) and no incidences of hospital acquired E-Coli.

Twelve complaints had been received by the hospital and the complaints process was met in all cases.

Services accredited by a national body:

- Joint Advisory Group (JAG) on GI endoscopy accreditation.

Services provided at the hospital under service level agreement:

- Clinical and/or non-clinical waste removal
- Interpreting services
- Grounds maintenance
- Security

Summary of this inspection

- Radiation protection service (for C arm in theatre)
- Laundry
- Maintenance of medical equipment
- Transport services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were robust incident reporting systems in place and we saw incidents were fully investigated and lessons learnt were shared with staff. Staff reported incidents confidently and there was a good track record on safety related issues. Staff could demonstrate understanding of duty of candour and provided examples of its implementation.
- Infection prevention and control practices were good, and departments were clean and well equipped. Record keeping and storage of medical records were good. Patient risk assessments and safety checks were very good. The local policy for medicines management followed recognised guidelines.
- Staffing levels were planned and monitored to keep patients safe at all times. Staffing levels across departments were good. There were good processes in place to monitor signs of deteriorating health and respond to medical emergencies.
- Overall, mandatory training figures were good and attendance was well managed. Where a shortfall had existed with three of the theatre team in 2016 an action plan had been put into place by managers to ensure staff met the 100% target of attendance. Staff had an awareness of safeguarding procedures and where to refer for additional support and guidance.
- The five steps for safer surgery checklist based on the World Health Organisation (WHO) checklist was consistently performed and embedded in culture and practice across the team.
- Arrangements in place to recognise and manage the deteriorating patient were very good and included using the national early warning score, escalation triggers, and sepsis management, in addition to scenario training led by clinical staff. At least one member of staff who had advanced airway training was always on duty.

However, we also found the following issues that the service provider should continue to improve:

- The hospital met the ethos of duty of candour in terms of apologising to patients and providing an explanation but did not strictly meet the group policy requirements or the full legal process, specifically in terms of meeting 10 day timescales to respond in writing to patients.

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- The provider should continue with audit and improvement work to improve staff compliance and consistency of completion of National Early Warning Score (NEWS).

Are services effective?

Good

We rated effective as good because:

- Patient care and treatment was planned and delivered in line with current evidence based guidance, standards and best practice recommendations. Outcomes for patients were good, with no concerns around rates of unplanned readmission, return to theatre or transfer to another hospital. Policy, standard operating procedures (SOPs) and guidance was discussed at the medical advisory committee (MAC) and in clinical governance committee and subgroups at the hospital.
- Patients confirmed pain relief and nutritional standards met their needs, with individual fasting times prior to surgery in line with national best practice guidelines. The service had maintained Joint Advisory Group (JAG) in Gastrointestinal Endoscopy accreditation since 2014.
- All staff received annual appraisals and were supported with revalidation requirements of professional bodies. Staff worked together proactively to ensure best care and treatment was delivered to patients. Staff we spoke with told us that they had a high level of support to develop their professional skills and training, including attending national conference events. All consultants had clear practising privileges agreements which set out the hospitals expectations of them, and ensured they were competent to carry out the treatment they provided.
- Consent to care and treatment processes were good and patients were able to make informed decisions. We observed evidence of effective multidisciplinary team working during our inspection between all members of the team at TVTC.

Are services caring?

Good

We rated caring as good because:

- All patients we spoke with told us they were treated courteously and respectfully and their privacy was maintained. There was a strong, visible patient centred culture within the organisation and embraced by all staff. Staff considered holistic quality patient care paramount to service delivery.
- Staff recognised the totality of patient need and there were examples where staff had gone the extra mile to meet this.
- Staff had an awareness of the '6Cs' that had been implemented in the hospital (nursing values drawn up by NHS England comprising; care, compassion, courage, communication,

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commitment and competence) and directed us to where the same was displayed at various locations around the unit. The 'Ramsay Way' correlated to the essence of the '6Cs' and reinforced care quality.

- Feedback from patients using the service was consistently positive and collected in a number of approaches, including use of an external provider for ongoing feedback. The hospital received positive responses for the Friends and Family Test (FFT) with an overall majority of months achieving 100% recommendations for the hospital. There had been initial problems with low response rates, with some months initially as low as 5%. A Health Care Assistant (HCA) had been leading on improving the response rate to a consistent 40%.

Are services responsive?

Good

We rated responsive as good because:

- TVTC planned and developed services to meet the needs of the local people which included flexibility and choice. Care and treatment was coordinated with other allied medical services.
- Referral to treatment times were consistently good during the reporting period October 2015 to September 2016. Patients were able to be seen quickly for appointments, and often chose to return back to the department for further treatment.
- The service made reasonable adjustments to support vulnerable patient groups. We noted that the hospital had staff in 'dementia friends' roles and had made adjustments to environment and access to the hospital for patients and relatives as a result of training and awareness.
- Managers proactively monitored flow (waiting times, delays and cancellations) and kept patients informed accordingly. Cancellations were reported as low.
- Service complaints were consistently low and staff responded to these in a timely manner.

Are services well-led?

Good

We rated well-led as good because:

- The leadership, governance and culture within the service were very good. There was a seamless consistency in the vision, strategy and culture of the organisation and 'The Ramsay Way' which was truly embraced by all staff.
- Governance arrangements were reviewed, adaptable to change and reflected best practice. Managers were focused on delivering quality care and improving patient outcomes. Managers acknowledged the importance of their team and recognised the value of their input into service provision.

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- Managers were visible, approachable, available at all times and were open and honest. Staff were proud to work for the organisation and morale was valued and following recent engagement activities staff satisfaction survey results had improved, after a short period in 2016 where morale of theatre staff had been affected negatively due to staffing pressures and increased workload.
- There were high levels of patient engagement. We saw positive examples of staff being proactive with visitors to the hospital and the local community.
- The security of funding to build a new hospital had ignited a new energy and positivity throughout the service.
- The leaders of the organisation listened to staff and actively supported staff creativity and staff initiatives. The level of staff engagement and support across the whole team was clearly evident when we spoke with staff during the inspection.

However:

- The hospital management team had acknowledged the risk register should be improved. We were assured that senior management had identified their local risks for example, restrictions of capacity, staff morale, and use of agency staff; however these needed to be better reflected in the risk register. These risks were discussed in senior meetings. The provider should continue with ongoing plans to improve their current hospital risk register.

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

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as good.

Incidents

- Staff at TVTC reported incidents electronically using a web-based data capture portal referred to as 'RiskMan' and in line with RHCUK policy. Staff informed us of types of incidents they would report such as patient safety matters and medication related issues. Incident reporting training formed part of the staff induction.
- There were 29 clinical incidents (64% of all reported) reported as attributable to the surgical or in-patient service from October 2015 to September 2016. These incidents were classified as no harm (56%), low harm (33%), moderate harm (9%) and severe/death (less than 3%). The service also reported six non-clinical incidents (55% of all reported). The rate of clinical and non-clinical incidents was lower than that of the rate of other independent acute hospitals.
- There had been one never event reported in 2016. A never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. The incident related to a dental extraction. The matter was appropriately reported to the local clinical commissioning group (CCG) and the patient. The investigation was thorough and timely, involved the patient and staff took immediate actions to remedy the situation which involved cascading lessons learnt and reappointing the patient.
- There had been one defined serious incident (SI) reported during the period October 2015 to September 2016. In brief, the investigation findings summarised a readmission following post-operative complications. The investigation report was timely and thorough. The same detailed the incident summary, chronology, investigation methodology, duty of candour, an analysis of findings, lessons learnt and action plans. There was also evidence of findings shared with the patient.
- The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Ramsay Health Care UK had provided training for senior staff on the principles of duty of candour. Staff at all levels had a good understanding of the duty and were able to describe the internal processes that would flow from a notifiable incident. We reviewed two investigations that had been conducted by the senior management team, these included evidence of thorough investigation and written apology to patients. It was not evident within the report that the duty of candour process was implemented within 10 working days of becoming aware of the incident. The hospital met the ethos of duty of candour in terms of apologising to patients and providing an explanation but did not strictly meet the group policy requirements or the full legal process, in terms of timescales to respond in writing to patients.
- We reviewed a selection of historic root cause analysis investigation reports and found these to be consistent in terms of content, timeliness and outcomes.
- Staff discussed incidents at the Senior Management Team (SMT) meeting and at Heads of Department (HoDs) meetings.

- Staff we spoke with told us of an open culture of reporting. Senior staff and managers shared lessons from incidents with all staff formally at ward meetings and informally during general daily work. Senior staff were automatically informed of higher level or serious incidents through the system. Serious incidents triggered escalation to corporate level.
- There had been no expected or unexpected deaths in the reporting period. Arrangements for mortality and morbidity review were captured in relevant sub-committees and heard by the Medical Advisory Committee (MAC).

Clinical Quality Dashboard or equivalent

- The service used the NHS Safety Thermometer approach and had good arrangements in place to assess, monitor and measure progress for the following types of harms; pressure ulcers, falls, catheter associated urinary tract infections (CAUTIs) and venous thromboembolism (VTE).
- There had been no reported incidence of pressure ulcers, falls or CAUTIs.
- VTE screening rates were higher than 95% from October 2015 to September 2016. One incident of hospital acquired VTE was reported in the period.
- We reviewed seven sets of care records and noted all patients had a VTE screening assessment completed.

Cleanliness, infection control and hygiene

- TVTC had a designated infection prevention and control committee (IPCC) which reported into the clinical governance committee (CGC). This group was responsible for infection prevention and control standards across the service.
- The unit was visibly clean, clutter-free and well-maintained.
- The unit displayed cleaning rotas agreed with landlord contractors (NHS Property Services) to meet the needs of the service and Ramsay Health Care UK standards.
- There had been no incidents of Methicillin Resistant Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Escherichia Coli (E. Coli) or Clostridium Difficile (C. Diff) reported from October 2015 to September 2016.
- The centre had a healthcare acquired infections (HCAI) surveillance policy. The centre did not carry out any primary hip, revision hip, primary knee, revision knee arthroplasties, other orthopaedic and trauma, spinal, breast, gynaecology, upper gastrointestinal and colorectal, urology, cardiothoracic, cranial or vascular procedures during the period from October 2015 to September 2016, and reported no mandatory infections.
- The centre, however, monitored all surgical site infections (SSIs) and reported eight during 2016. Staff investigated all reported SSIs and these were discussed at IPCC. Seven of the eight were superficial wound infections which required minimal or no treatment. The remaining incident reported as an SI required the patient to be readmitted to a neighbouring hospital for additional treatment. There were no themes or trends identified.
- We observed staff following hand hygiene procedures and 'bare below the elbow' uniform guidance. Staff regularly washed their hands and used hand gels prior to patient contact and clinical procedures. Patients were actively encouraged to follow hand hygiene procedures. There were facilities for hand washing and visual signage throughout the unit.
- There was a dedicated sterile services department at a local sister hospital site in Newcastle. This facility serviced TVTC with twice-daily visits. We also observed dedicated decontamination areas within the endoscopy theatre with clean and dirty rooms for endoscope processing. Staff were trained in endoscope processing and the handling and storage of cleaning substances. There was a Control of Substances Hazardous to Health (COSHH) file on the unit for reference.
- We observed good intraoperative theatre practices. Hand decontamination took place outside theatre due to the location of the washing facilities. We also observed appropriate patient preparation such as the use of sterile drapes, skin preparation and the use of personal protective equipment (PPE).
- Staff had training in infection prevention and control (IPC) and had to achieve competence in practices such as wound care, insertion of vascular access devices and catheter care. There was a lead nurse for IPC and a number of staff had special interest in this area.
- Staff completed an IPC Environmental Audit benchmarking against local policy, professional body standards and health and safety legislation. The audit comprised eight key performance sections looking at IPC management, environmental cleanliness, clinical equipment, decontamination, clinical practices, sharps handling, waste disposal and hand washing. Overall, individual section ratings and overall ratings were very

good. In August 2016, of the 89 standards measured, TVTC were compliant in 84 providing 94% overall compliance. Auditors identified some environmental wear and tear in the shared building which impacted on compliance in this section. The management team improved communication with the landlords of the building to influence improvement.

- The service also completed monthly hand hygiene audits covering adherence to policy, observed practice and spot-checks. Auditors found consistently good compliance and, in August 2016, reported this as 99% overall.
- Staff at TVTC took part in the 'Antibiotic Awareness Day' to promote key IPC initiatives across the service and raise staff awareness. Such initiatives had seen infection rates per percentage of admissions to reduce year on year from 2013 (0.45%) to 2016 (less than 0.15%).
- We reviewed IPCC meeting minutes. These meetings were co-joined with the nearby Ramsay Health Care UK hospital and were well-attended. The meeting reviewed on-going actions and worked through standard agenda items such as policies, audit, HCAI surveillance and training.
- TVTC reported good audit results for standards of professional practice in the peripheral venous cannula care bundle (PVCCB). Standards were measured against insertion of the device as well as on-going care. Between 82%-91% compliance was reported against standards. Staff identified the use of gloves and the wearing of PPE to be inconsistent. Staff completed an action plan to ensure a consistent approach.
- In the PLACE audit between February and June 2016, the cleanliness compliance score was reported as 98% (in line with England average).
- We reviewed the IPCC 2016 annual plan. The same detailed key IPC successes (full compliance with IPCC audit programme, good reporting and training) and areas for improvement (to increase patient awareness of hand hygiene).
- Staff handled and managed specimens in accordance with local IPC guidelines and health and safety policy. All specimens (microbiology, histology and acute) were labelled with all relevant patient demographics, logged electronically (and on paper records) and stored safely prior to collection.

Environment and equipment

- TVTC was accommodated in two areas within a large shared NHS facility.
- The unit was uncluttered, access to equipment and storage facilities were good.
- The surgical day unit situated on the third floor was a modern facility designed to facilitate care for this cohort. This comprised some shared occupancy in waiting areas, with private pre-operative consultation areas and changing facilities.
- The centre housed two theatre suites, both non-laminar flow theatres. However one was specifically allocated to deal with those procedures requiring general anaesthesia and the other primarily to deal with more of the diagnostic investigations.
- All theatre and anaesthetic equipment had been checked in accordance with manufacturer recommendations and recognised professional standards such as Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. We were provided with sight of equipment checklists and asset replacement register detailing robust equipment safety checks and replacement programmes.
- There was separate clean and dirty room provision for decontamination of endoscopy equipment. Endoscopy equipment checks and decontamination processes were validated by an external company. We had sight of the latest validation summary report from December 2016, which confirmed periodic validity for the coming 12 months.
- The unit resuscitation trolley was situated in the recovery area. Staff performed and documented daily checks against a given checklist. Suction, oxygen and emergency call systems were available at recovery beds.
- The day unit also housed the blood transfusion trolley which held specific equipment in the event of the need for an urgent transfusion. The trolley detailed an equipment checklist. Blood components were stored off site by agreement.
- We found all equipment to display an electrical testing sticker and medical engineering check record confirming the equipment to be safe to use. All tests and calibration checks were in date.
- We found arrangements for waste segregation and disposal to follow recognised standards. We also observed good management and safe disposal of sharps.

- Two recovery chairs in the day unit met bariatric requirements. Operating and transfer trollies were also suitable for bariatric patients.
- In the PLACE assessment, during the period from February to June 2016, auditors reported 'condition, appearance and maintenance' to be 95%, better than England average of 93%.
- Staff raised any concerns about environmental or equipment issues to their manager and the issue was discussed at the health and safety committee before presentation to the senior management team.
- The centre had requested and secured a designated landlord representative to discuss estates issues which would otherwise be outside their control.
- Environmental audit was captured within the IPC audit. Overall, compliance against the key indicators was good.

Medicines

- TVTC had a Service Level Agreement (SLA) with an external company for the provision of pharmacy services. The Ramsay Group Pharmacist managed the agreement on behalf of TVTC.
- The contract provided for pharmacist attendance on site (eight hours per quarter) with advice and guidance by telephone when required. The pharmacist monitored medicine management processes, controlled drugs and prescribing audits and supported and supervised the activities undertaken by the pharmacy technician (who attended twice weekly to manage stock).
- Patients were encouraged not to bring medicines into hospital as part of pre-assessment advice. Safe locker storage was accessible for patients that did bring in medication during admission.
- We reviewed seven medicine prescription charts at random and found these to be correctly completed. Patient allergies were clearly documented.
- We observed safe storage of all medicines, including controlled drugs (CDs) at TVTC.
- All medications were stored in a locked facility when not in use. The anaesthetist and operating department assistant (ODPs) pre-prepared and labelled medications for use during the anaesthetic process in accordance with local policy.
- Staff stored medications requiring refrigeration in small fridges in locked rooms and monitored temperatures daily. Staff followed the local procedure in the event of a temperature reading exceeding upper safe limits or falling below the lower threshold.
- Staff stored CDs in a double locked cupboard within one of the anaesthetic rooms. The CD keys were held separately from the general medical cupboard keys. When not in use the keys were stored in a key coded locked unit. Staff completed CD checks twice daily and endorsed the CD book to confirm this was completed.
- TVTC completed monthly CD audit checks against local policy standards, Department of Health Regulations, professional standards and General Pharmaceutical Council guidelines. Auditors rated compliance against a 'RAG' (red/amber/green) rating. From July to September 2016 compliance was consistently above 90%, but did not meet the 100% target. In September 2016, auditors identified some documentation needed improvement and an action plan was completed to meet identified shortfalls.
- The medicines management audit showed consistently good results in excess of 90% compliance against local and national policy. Auditors identified an issue with medicines storage in one fridge which showed ranges outside the safe upper and lower temperature limit. Staff remedied this immediately with a maintenance engineer attending to repair.

Records

- Staff stored patient records in locked trolleys when not in use. There was no patient identifiable information visible or on display in non-secure staff monitored areas.
- We reviewed seven sets of patient records. All records were complete, accurate, legible and up-to-date. This included referral information, pre-operative assessment, operating records and discharge information.
- Nursing documentation was good with standardised risk assessments and care pathways.
- TVTC completed medical records audit benchmarking against local policy and professional standards (Royal College of Anaesthetists, Nursing and Midwifery Council and General Medical Council). Auditors reviewed the records under three sections – administration, criteria against healthcare entries and a specific section for visiting consultants. Compliance was consistently good

and in excess of 90%. Auditors identified some omissions with registered nurses failing to sign for delegated healthcare assistant activities. Staff put action plans in place to improve this finding.

- TVTC completed a further anaesthetic audit in line with The Association of Anaesthetist of Great Britain and Ireland (AAGBI) and Royal College standards. The auditors considered 26 key performance indicators such as consent issues, equipment checks, anaesthetic record documentation, patient monitoring and post-operative orders. Overall, compliance was good; however there was some variability in compliance across the quality of documentation indicators. The outcomes were followed up at the governance group and all locum staff were asked to review all local policy requirements.
- TVTC held a set of patient notes for all patients attending the centre. Managers planned to migrate all patient records onto an electronic patient record when the corporate trial had been completed.
- Historically, Ramsay Health Care UK maintained an electronic implant register to record breast implants against patient identification. TVTC had registered for the National Breast and Implant Register where patients, providing consent, have their details stored within the registry.

Safeguarding

- Ramsay Health Care UK had a safeguarding policy and staff we spoke with at TVTC could access this on the intranet and seek advice from the hospital lead. We observed poster information to support staff at various locations in the day unit.
- Safeguarding training was provided as part of mandatory training. We found that 100% of staff had received safeguarding vulnerable adults level one training.
- The matron was the lead for safeguarding and had attended level two and three safeguarding training for adults and children. The matron was also responsible for any issues related to female genital mutilation (FGM) in line with national guidance (revised publication April 2016: Multi-agency statutory guidance on female genital mutilation).
- There were no safeguarding incidents reported at TVTC during 2016.
- Staff understood safeguarding processes and knew where to get further advice. The internal procedures were advertised on the intranet.

Mandatory training

- Staff completed core mandatory training modules by way of e-learning and face-to-face sessions. This included fire safety, health and safety, equality, human rights and workplace diversity, infection control, annual clinical updates, manual handling, resuscitation, information security, data protection, customer service, safeguarding, prevent, medical gases and sharps and blood-borne viruses.
- Mandatory training compliance was good overall with some variation between clinical and non-clinical staff. Module compliance rates were recorded. These ranged from 100% (in the majority of topics) to 64% for medical gas training reported for the surgical ward staff group at the time of inspection. Theatre staff group mandatory training was also good with the majority of core elements reported in excess of 95% compliance with the exception of the customer care module reported at 33%. Senior staff were aware that two staff required training and had plans to ensure targets were achieved.
- Consultants with practising privileges attended mandatory training at their employing NHS trust and attendance was monitored and reported to TVTC as part of the appraisal and employment process.
- Staff confirmed all mandatory training requirements were booked in advance during the course of the year to ensure compliance in the training period.
- Staff completed training and development workbooks which included evidence of mandatory training completion, training targets, development reviews and competency frameworks.

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

- Managers assessed all referrals into TVTC to ensure they met day case criteria and the admissions policy. Where there were concerns about a particular referral due to patient history or the nature of the procedure to be performed, this would be discussed further with the referrer and internally with the clinical team. Any decision to reject a referral would be solely due to patient safety issues.

Good

Surgery

- All patients had a pre-assessment consultation in line with best practice. This ensured all clinical information was obtained, the patient could raise any questions and particular pre-operative preparation could be discussed, such as bowel preparation.
- Staff recorded all patient clinical observations as part of the pre-operative assessment check. Where observations were noted to be outside normal parameters such as a high blood pressure reading, staff alerted the anaesthetist and consultant prior to the procedure. Staff deferred or cancelled procedures if it was unsafe to proceed. Where the patient required further review, the anaesthetist and consultant would write to the patient's referrer informing them of the clinical reasons why the procedure did not go ahead and what to do to correct this prior to re-referral.
- The centre had a recognition and management of the deteriorating patient policy which included detailed guidance on the using the National Early Warning Score (NEWS), escalation triggers, ABCDE (airway, breathing, circulation, disability and exposure) assessment and sepsis management. Recent changes to the adoption of a 'National' change to the EWS had been reported as causing some staff to not fully complete parameters and trigger reporting. Audit of the NEWS had identified this gap and additional training had been provided to support compliance and staff understanding.
- TVTC ensured at least one member of staff on duty at all times was trained in advanced life support (ALS). Three members of the theatre team also planned on completing this specialist training course in the coming 12 months. Staff performed scenario training on regular occasions to assess the team and individual competence in emergency situations.
- We also reviewed examples of the World Health Organisation (WHO) Guidelines for Safer Surgery Checklist and all were found to be completed in full in all cases. Surgery specific checklists were reviewed in line with best practice for endoscopy, cosmetic surgery and general surgery. Staff working in theatres at TVTC were compliant with the five steps to safer surgery and applied the WHO surgical checklist to practice. Additionally, TVTC had also developed a number of intra-operative safety checks such as swab counts, stop before you block, site marking, instrument handling and specimen management.
- Staff at TVTC completed a surgical safety audit tool to benchmark compliance against the WHO Checklist. The audit covered areas such as team briefings, checklist documentation completion, sign-in checks, surgical pause, sign-out and debrief. Auditors found compliance was excellent with consistently good figures in excess of 95%. In August 2016, all elements of the audit recorded 100% compliance.
- There was an agreement in place with a local NHS trust for the transfer of patients who became unwell and required admission. Staff we spoke with were familiar with arrangements and process in such an event.
- TVTC offered an out-of-hours telephone helpline manned by registered nurses should a patient require any further advice after the surgical procedure. The nurse made an assessment of the patient's needs and escalated accordingly which may involve liaising with the consultant, anaesthetist, a review appointment or immediate referral to A&E.
- Consultants provided cross cover within the same specialism. This ensured cover for periods of absence and additional work commitments.
- There was a clear process and policy in place for the management of patients who required a blood transfusion. Firstly, staff maintained an emergency blood transfusion trolley for ease of access in the case of an emergency. As no blood was stored on site, staff followed local protocol and requested blood from a neighbouring NHS trust. Staff confirmed blood was on-site within 15 minutes. TVTC had a dedicated blood transfusion lead nurse to keep staff abreast of current guidelines and local procedural changes. Staff had received training for the sampling, ordering and administration of blood transfusion. Staff confirmed where the patient's condition required greater circulatory support; staff arranged an emergency transfer by ambulance to the local NHS hospital.
- We were provided with sight of a 'care of the deteriorating patient audit'. The audit considered compliance against local policy, National Institute of Health and Care Excellence (NICE) guidance, national safety reports and Royal College standards. NICE auditors, in September 2016 reported compliance of 96%. Auditors commented on observations recorded in pathway documentation but not transferred onto NEWS observation charts and temperature recordings being omitted. Auditors discussed findings with the lead and an action plan to ensure staff compliance was drafted.
- The team provided a follow up service 48 hours after the patient was discharged home. Nursing staff made a

telephone call to all patients and documented any issues or comments for each patient. Patients were given a helpline telephone number and nursing staff supported this service on call, overnight and at weekends. Any issues or concerns could be escalated to the consultant or the cover doctor. Staff we spoke with were clear about the arrangements and reported that they worked well.

- Staff at TVTC carried out real-time scenario based exercises to simulate circumstances where a patient may deteriorate to test out locally agreed procedures, staff competence and agreements with healthcare partners.

Nursing and support staffing

- Ramsay Health Care UK and TVTC operated an electronic rostering system for nursing shifts, called Allocate. This allowed department heads to manage rotas up to six weeks in advance of proposed lists taking into consideration list duration, patient acuity and skill mix.
- Heads of Departments continued to monitor patient activity and acuity in daily safety huddles. The team reviewed the plan for the current day and seven day forward view of staffing. This enabled changes to be made to meet periods of increased or changing demand.
- The centre provided 'in-patient' nurse staffing figures. There was reported to be 3.2 registered nurses (RNs) and 2.5 health care assistant (HCA) whole time equivalents (WTE) in post on 1 October 2016. Theatre staffing recorded 4.3 RN WTEs and 5.3 WTEs for operating department practitioners (ODPs) and HCAs. The centre also reported variable registered nurse bank and agency staff usage during 2016. In in-patients areas, the figure peaked at 26% in July, reducing to 6% in September. In theatre, bank and agency rates had remained static throughout the year averaging 20% monthly. ODP and HCA bank and agency usage was less than 5%.
- In-patient and theatre nurse staff sickness rates were lower than the average of other independent acute hospitals. There had been some staff turnover during the period, reported as 29% for in-patient nurses and 18% for theatre nurse staffing.
- The centre reported 0.57 WTE in-patient nurse posts vacant and 2.43 WTE in theatre.
- Rota shortfalls were covered by existing staff and known bank staff. We reviewed staffing rotas and these showed no unfilled shifts.
- The centre identified retention and recruitment of theatre staff was an issue however recognised this was against a backdrop of a limited local pool and national shortage. Managers had a recruitment plan which actively utilised social media, recruitment agencies and open days. The centre had recently appointed two theatre staff.
- We observed good handover processes, safety briefing approaches and nursing staff were observed to have good relationships with consultant and medical staff.

Medical staffing

- TVTC granted and reviewed practising privileges (PPs) in line with local policy and national guidance. All consultants seeking PPs provided the organisation with standard information showing that they fulfilled the criteria for employment. This included evidence of qualifications and experience, pre-employment checks, professional body registration, interview and final Medical Advisory Committee (MAC) review. On-going review of those with PPs was monitored by way of annual appraisal, report activity, patient outcomes, reaccreditation, re-credentialing and verification of scope of practice.
- The centre reported 43 doctors or dentists were employed or were practising under rules or privileges. There were also three medical practitioners who held practising privileges for cosmetic surgery and all were on the General Medical Council (GMC) specialist register. The senior management team held information for every consultant.
- TVTC employed two anaesthetists and one surgeon. They were all appraised locally and managed by the senior team. Revalidation processes were carried out and support for study was available.
- Patients were admitted under a named consultant who had clinical responsibility however staff at TVTC also took ownership of all patients under their care. We observed professional and effective integrated working between existing TVTC staff and visiting consultants.
- There were robust arrangements for consultants to cover one another when required. Staff we spoke with told us of arrangements for nominated deputies being clear and organised.

Good

Surgery

- There was a member of the medical team on site until the last patient was discharged home from the hospital.

Emergency awareness and training

- TVTC staff shared the building with NHS colleagues and were subject to some shared responsibility when responding to an emergency or major incident within the estate such as a fire.
- Managers considered potential risks when planning services and this was also noted during periods of adverse weather which may cause disruption to staff or patients.
- Staff accessed policies in the event of major incidents. Staff had good access to policy and senior staff were available for advice when an emergency response was required. Escalation arrangements were seen to be good across the provider and local hospital network.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We found patient care and treatment was planned and delivered in accordance with current national guidance and best practice guidelines from the National Institute of Health and Care Excellence (NICE), The Association of Anaesthetics and The Royal College of Surgeons.
- Staff considered new and reviewed corporate policies, local procedures and clinical guidelines in specialist committee meetings and the MAC. We reviewed a number of local policies which referenced evidence underpinning local practices.
- TVTC took part in a number of local and national audits. These included patient reported outcome measures (PROMs) and commissioning for quality and innovation (CQUINs).
- The service reviewed evidence and best practice guidelines to develop care pathways.
- TVTC developed an Endoscopy User Group (EUG) to review guidance, standards and best practice in the provision of endoscopy related services.
- Endoscopy services were accredited by the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy in February 2014. This provided assurance of quality standards in gastrointestinal care. Staff submitted annual scorecards to the JAG to maintain accreditation.
- TVTC completed a self-assessment checklist of compliance against National Confidential Enquiry into Patient Outcome and Death (NCEPOD) measures for cosmetic surgery. Of the 12 standards, TVTC reported compliance in ten and partial compliance in two (formal training programmes and national outcomes database).
- Managers at TVTC carried out a detailed audit programme to monitor compliance and benchmarking against local and national evidence based guidelines and treatment standards. Managers discussed outcomes of audit activity with individual staff, HoDs and reported findings into the corporate governance structures.
- TVTC contributed to the private healthcare information network (PHIN).

Pain relief

- Staff acknowledged patients were often concerned about pain management after their procedure.
- Pain assessment formed part of the pre-operative consultation. We noted pain management options were discussed and documented in the patient record. All patients' records reviewed made reference to pain management and individual preferences were taken into account.
- Patients undergoing endoscopy procedures had a pain assessment pre and post procedure. Staff followed up pain management outcomes with their comfort call the day after the procedure.
- Patients accessed an online satisfaction survey and one of the questions therein asked 'did staff do everything they could to control pain'? One hundred percent of respondents confirmed their pain to be managed effectively.
- The centre staff referenced the post-operative pain management policy for guidance on best practice where required.
- Staff completed a pain assessment as part of their NEWS observations. All charts reviewed had a pain score recorded in the relevant field.
- We spoke to seven patients recovering from a range of surgical procedures. Patients told us that they had good

pain control. One patient confirmed her request for non-pharmaceutical pain relief was granted and she was given an alternative. This made her less distressed and more comfortable during and after the procedure.

Nutrition and hydration

- Staff confirmed how appropriate preparation for day case surgery was important and this included nutrition and hydration considerations.
- Patients had a nutritional assessment at their consultation and were informed of the need for pre-operative fasting where appropriate.
- Staff added how certain care pathways emphasised the importance of considering nutrition and hydration factors. This was particularly important for vulnerable patients or those that had undergone particular procedures.
- TVTC followed national guidance on pre-operative fasting and ensured all fasting requirements were kept to a minimum to avoid patients distress however to ensure safety for any procedure. This was further supported by staggering admission times.
- All patients were provided with drinks and food after their procedures. Patients had anti-sickness medications prescribed in the event they felt nauseous post-procedure.
- Staff stated they only completed food and fluid charts if the recovery was prolonged or if particular concerns had been highlighted pre-operatively.
- Patients completed an on-line survey which covered nutrition and hydration related questions. One hundred per cent of respondents were satisfied with this element of their care.

Patient outcomes

- There were 6,958 visits to theatre from October 2015 to September 2016. There had been four cases (less than 1%) of readmission within 28 days of discharge from the hospital, four unplanned (less than 1%) returns to theatre and ten cases (less than 1%) of unplanned transfers. These figures were not high when compared to other independent hospitals. There were no particular themes or trends.
- All unplanned readmissions and transfers were discussed within the department, at the clinical governance group and MAC.
- TVTC participated in Patient Reported Outcome Measures (PROMs) for varicose vein and groin hernia surgery (NHS funded patients only).
- From April 2015 to March 2016, PROMs for groin hernia showed TVTC health outcomes were within the estimated range for EQ-5D (measure of generic health status) Index. Out of 53 modelled records, 45.3% were reported as improved and 30.2% as worsened. In the EQ-VAS (overall health related quality of life) measure, of 48 modelled records reviewed, 37.5% were reported as improved and 43.8% as worsened.
- TVTC PROMs findings against varicose vein surgery could not be calculated as there were less than 30 modelled records. Auditors reported EQ-5D Index measures (from five modelled records), 80% were reported as improved and 20% as worsened. EQ-VAS findings reported 40% had improved and 20% had worsened. The Aberdeen Varicose Vein Score reported 80% as improved and 20% as worsened.

Competent staff

- All staff starting employment with TVTC had their qualifications verified and checked to ensure they had the right skills, knowledge and experience for the role applied for.
- There is a staff induction on commencing work at TVTC which covers corporate overview, local practices and key core training requirements. Additionally, all new staff completed a period of supervised practice to allow for completion of local competencies relevant to the role.
- All in-patient department staff had an appraisal completed during 2016. All staff confirmed they had completed an appraisal in the previous 12 months. The appraisal process formed the basis for training and learning needs analysis.
- Staff accessed training courses and study options via the Ramsay Academy, on-line and where appropriate attended external events.
- There was a 100% validation of professional registration for nurses covering in-patient areas and theatre. We reviewed a registered nurse portfolio for revalidation purposes. This was very professionally maintained with evidence of practice hours, continuing professional development, practice related feedback, reflective accounts and discussion.
- On an annual basis, the consultant with practising privileges provided a summary report related to activity

and performance over the previous 12 months to inform appraisal and revalidation. Consultants provided a copy of their annual appraisal from their trust once performed. Any performance or competence issue outside of this cycle was raised through a process called 'facility rules' which guides practice and management of those accredited practitioners performing under practising privileges. This process was managed by the MAC.

- All consultant cosmetic surgeons (of which there were three), all met the required standards for inclusion on the specialist register and all were members of The British Association of Aesthetic Plastic Surgeons (BAAPS) or The British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS). This accreditation set its own specific CPD and practice requirements to ensure competence.
- There was a 100% completion rate of validation of professional registration for doctors and dentists working or practising under rules or privileges.
- The TVTC on-line survey asked patients for their view on staff competence. 96% of patients confirmed nurses to be competent and 94% for doctors.

Multidisciplinary working

- Care was coordinated between pre-assessment, the day unit and theatre staff ensuring the multidisciplinary team (MDT) was involved in care.
- TVTC staff liaised with local trusts, GPs and referrers to ensure all relevant parties were informed and involved in the care accordingly.
- TVTC had good relationships with local partner care providers and referral processes for on-going care needs were embedded.
- The flow of information to carers and family members involved in supporting care was efficient and inclusive.

Access to information

- All staff had good access to policies and procedures through the corporate intranet.
- We reviewed care bundles and pathways that contained information staff needed to deliver effective care and treatment and included risk assessments, care plans and medical notes.
- TVTC received referrals and shared relevant information with the patients GP via an electronic portal. The service held regular invitation meetings with local referrers to give them the opportunity to follow the patient pathway and identify ways to improve information exchange.
- Staff provided discharge information to the patient after the procedure. Staff sent a copy of the same to the patient's GP, referrer and a copy remained in the patient record. The service did not send any formal discharge record out in the electronic format.
- Staff confirmed if a GP or a referrer called to clarify information or seek advice, this would be referred onto the consultant or a senior member of the nursing team to deal with immediately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave consent to treatment during pre-assessment consultation and the same was revisited on the day of the procedure.
- We observed consultant surgeons and anaesthetists taking time to discuss the procedure with the patient, highlighting proposed benefits, detailing relevant risks and answering questions relevant to an informed consenting process. Documentation was good and in line with national guidance from the General Medical Council (GMC) and Royal College of Surgeons (RCS).
- Consent audit results in September 2016 showed 94% compliance with consent processes. Auditors identified some documentation management issues require improvement. Staff completed an action plan following the audit to address identified compliance shortfalls.
- Patients were given literature about the consent process. All patients we spoke with, at various stages of the care pathway, confirmed they had received helpful information about their procedure which detailed the risks and benefits of surgery allowing them to make an informed choice.
- RHCUK had corporate policies to guide practice in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) procedures. There was a site lead for MCA and DoLS. All staff had received training on MCA and DoLS as part of their mandatory training and were aware of how to seek guidance when necessary

Are surgery services caring?

Good

Surgery

Good

We rated caring as good.

Compassionate care

- The 'Ramsay Way' emphasised the importance of delivering care with compassion.
- From April to September 2016, the Family and Friends Test confirmed 100% of patients would recommend the service as a place to receive care. Staff identified response rates required improvement and during October to December made a conscious effort to promote patients views from this medium. Response rates averaged 44% (above national average) in the day unit during this period.
- We spent considerable time observing care delivery and interaction. Staff treated patients with genuine kindness and respect. Staff were observed being courteous and helpful.
- Staff introduced themselves to patients and confirmed they would be the person responsible for their care during their time on the unit.
- We spoke to seven patients and all responses were positive. Patients described the care they received as "brilliant", "so good, I'd do it all again" and there was a consensus that staff of all grades and disciplines "really care" about what they do. All patients confirmed they would choose to come back to TVTC should they require a further day case surgical procedure.
- We observed nurses responding to patient requests promptly and answering nurse calls in a timely manner.
- During summer 2016, the service received four hot alerts (patient feedback identified by the external research company managing the on-line portal) regarding the care received at TVTC. Three of the four comments were positive, "care exceeded my expectations", "the consultant was excellent and I was fully informed throughout" and "staff were marvellous".
- Staff had an awareness of the '6Cs' that had been implemented in the hospital (Nursing values drawn up by NHS England comprising care, compassion, courage, communication, commitment and competence) and directed us to where the same was displayed at various locations around the unit. The Ramsay Way correlated to the essence of the '6Cs' and reinforced care quality.
- One patient required a particular pre-operative preparation prior to her surgical procedure however was unable to attend the centre to collect the prescription. A member of staff personally delivered this to the patient's home and explained how to administer the same.
- Patients confirmed privacy and dignity was maintained at all times. There were private changing areas and consultation rooms in the pre-assessment area of the day unit. There were also some curtain-partitioned areas which were not fully conducive to having private and confidential dialogue. Staff confirmed they had received no patient concerns about consultations taking place in these areas.

Understanding and involvement of patients and those close to them

- All patients we spoke with had been given information and had been fully involved in decisions about their treatment. People told us they felt involved in their care. Consultants and nursing staff were visible and available on the unit for patients and relatives could speak with them on request.
- Patients added TVTC provided them with necessary information prior to attending the unit and allowed time to ask questions and consider treatment options.
- Due to the size and nature of the day unit, relatives attending with the patient were asked to remain in the waiting area until the procedure had been completed and the patient was fully recovered. Staff confirmed they alerted all visitors when the procedure had been completed to reassure them and we observed this practice during inspection. Staff also confirmed where it was in the patient's best interests to have someone present with them throughout, this could be accommodated.

Emotional support

- Staff acknowledged and were aware of potential and actual patient anxiety ahead of their surgical procedure.
- Staff ensured all patients were suitably informed, had the opportunity to raise any concerns or queries and were provided time to discuss particular worries for them. One patient had a particular concern about a surgical procedure and how this may affect their employment. Staff addressed the patient's concerns and arranged for the procedure to be staged over multiple visits.

Good

Surgery

- One patient was especially anxious about a procedure however had built up a relationship with one particular member of staff. Managers allowed the staff member to be present for all patient appointments, stay with the patient throughout the care pathway and be present during the recovery prior to discharge.
- TVTC staff and consultants considered the physical and the emotional wellbeing with proportionate response. Where additional emotional or psychological support was required, staff arranged this. Where appropriate, cooling off periods were adhered to and treatment was stalled until the patient was fully consenting and happy to proceed.
- TVTC established strong professional networks with psychologists and counselling services should this be of benefit to a patient's care. These allied professionals attended patient consultations where required.
- A number of patients commented how the calm and relaxed atmosphere within the unit further reduced their anxiety as everyone seemed so "professional and competent".
- Staff completed a follow up call of all patients who underwent general anaesthetic the following day or for any patient if there were particular concerns to check they were well after the procedure.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The service provided 98% of surgical treatment to NHS patients and 2% to privately funded patients. Private patients did not receive priority over NHS patients and staff we spoke with told us there was no difference in care and service. This was apparent during our visit.
- TVTC received the majority of work from local Clinical Commissioning Groups (CCGs) in and around Teesside. TVTC developed and planned services in conjunction with relevant interested parties and to meet local need.
- TVTC had various service level agreements (SLAs) in place with a number of providers for radiology, pathology, pharmacy, blood provision, sterile services and microbiology support. This also included agreements with a local hospital for urgent transfer and escalation of care.
- Patients were involved in the booking process which ensured convenient appointment slots were secured. Staff offered patients appointments during normal office hours, in the evening and at weekends (Saturday).
- We observed staff working flexibly to deal with busy times and increased activity. TVTC facilities were restricted due to the estates facility they shared however capacity and demand was managed very well. Managers ensured flexibility to meet patient needs during periods of increased demand.

Access and flow

- There had been almost 7,000 day case attendances from October 2015 to September 2016. There was an effective utilisation of the facility and streamlined processes to ensure efficient patient flow from booking to discharge.
- All patients received prompt pre-assessment consultation upon receipt of referral and appointment times were staged to prevent unnecessary waiting. These were generally aligned to morning, afternoon or evening lists.
- To effectively monitor and prevent 18 week breaches occurring, RHCUK corporate team circulated weekly elective wait monitoring reports to each unit. This assisted managers in monitoring patient waits and improving admission processes.
- From October 2015 to September 2016, above 90% of patients were admitted for treatment within 18 weeks of referral (RTTs).
- Senior staff we spoke with told us private patients could theoretically choose a date for treatment which may exceed an 18 week window however this rarely occurred in practice.
- There had been 52 cancelled procedures for non-clinical reasons from October 2015 to September 2016. The majority of the cancellations resulted from an unforeseeable personal staff event. Staff reappointed all patients concerned within 28 days.
- The centre actively monitored cancellation data and analysed trends related to patient cancellation, clinical need, non-clinical need and other related matters. Any cancellation was immediately reported to the patient, the referrer and all efforts were taken to reappoint at the

earliest safe opportunity. Staff identified a shortage in some sterile services equipment may impact on cancellations therefore worked with sterile services colleagues at a neighbouring hospital to ensure turnaround times were reduced as an interim measure whilst awaiting the purchase on additional surgical kit.
- Managers had compiled a 'cover for consultants' SOP in the event of clinic or theatre cancellation without the requisite six week notice.
- Centre managers monitored theatre utilisation at daily huddles to identify on-going and future capacity needs. Managers made use of gaps created from patient cancellations by offering other waiting patients earlier dates for their procedure if appropriate. The central team compiled weekly theatre utilisation reports. Schedule utilisation varied slightly between the two theatres. In November and December 2016, this averaged 91% in theatre one and 84% in theatre two.
- Nursing staff were able to arrange a patient review or readmission to TVTC if necessary as part of the helpline process.

Meeting people's individual needs

- Staff planned services at TVTC to meet the needs of all adult patients irrespective of age, disability, gender, race, religion or belief.
- The service at TVTC made reasonable adjustments to support the needs of patients with more complex needs such as those living with dementia or those with particular needs as a result of a learning disability. We noted some dementia friendly signage had been displayed to reduce environmental conflict and anxiety triggers for this particular cohort of patients.
- Following some constructive feedback from a carer of a patient, staff at TVTC underwent additional dementia awareness training. This provided additional knowledge and skills to care for people living with dementia and raised awareness of environmental factors which may cause conflict.
- Staff confirmed they paid particular attention to patients who had specific needs or preferences identified during the pre-assessment consultation and with reference to the screening questionnaire.
- Staff confirmed they facilitated pre-visits and allowed carer attendance throughout the care pathway for those patients who requested this level of support.
- The service advertised the chaperone service and staff were fully aware of the corresponding policy.
- Staff confirmed they accessed interpreter, sign-language and other support services to meet individual patient needs where required. This service was well understood by the team, used frequently, and responded to the recognised diversity and needs of the local population.
- Patient information leaflets were available, well written and displayed in patient areas. These were disease specific, covered health information topics and all provided unit contact details in the event of concerns or problems on discharge. Information leaflets were in easy to read formats and described what to expect when undergoing surgery, endoscopy and aftercare Leaflets were available in braille and languages other than English.
- TVTC had a range of disease specific and procedure specific leaflets for patient reference. Patients were given access to a 24 hour helpline to support them with any concerns after discharge. Nursing staff contacted all patients 48 hours after discharge to offer advice and support if needed.

Learning from complaints and concerns

- TVTC had a policy for the management of complaints which was used in practice.
- The general manager had overall responsibility to oversee the complaints process at TVTC.
- All complaints were entered onto the 'RiskMan' incident reporting system which provided a function to disseminate information to all relevant personnel locally, regionally and nationally where appropriate.
- Staff were conversant with the policy, knew how to escalate concerns and where to access the guidance for further information.
- All staff had training in customer service which covered dealing with complaints.
- The SMT were informed of all complaints as part of the governance arrangements at TVTC. Complaints were a standard agenda item at senior management team meetings and department head meetings. Where relevant complaints were also discussed at relevant sub-committees.
- Patients were able to raise concerns about care through a variety of media (such as 'we value your opinion' leaflets, via the formal complaints process, family and

friends test, through on-line surveys and informally to staff) and we noted information on feedback mechanisms was advertised around the unit. TVTC also monitored responses from patients in NHS Choices.

- The unit recorded 12 complaints during the period from October 2015 to September 2016. There were no particular themes or trends. All complaints had been logged onto the incident reporting system and the general manager had acknowledged receipt within 48 hours in accordance with local policy.
- The general manager completed investigations in a timely manner and with the exception of two, provided a full written response to the complainant within 20 working days. Where delays had occurred, the complaint was informed of the reasons for this (awaiting external stakeholder or multi-agency response).
- All complaint findings were signed off by the SMT before sending onto the complainant. The general manager offered a face-to-face meeting with all complainants. There had been no complaints escalated to independent external adjudication or the Parliamentary and Health Service Ombudsman.
- Learning from a complaint was shared through the committee structure. Senior staff shared actions or lessons learnt through team meetings and with individuals when necessary. TVTC also escalated complaint findings to regional and national colleagues to share learning outcomes.
- A recent complaint from a relative on behalf of her mother who was living with dementia led to a review of care provision for this particular cohort of patients. The team worked to increase staff awareness by commissioning training sessions for all staff from the Alzheimer's Society with a number of staff taking this further by completing short dementia courses leading to 'dementia champion' status.

Are surgery services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- Ramsay Health Care UK and TVTC had a clear corporate vision, strategy and business model.
- The vision, strategy and culture within the organisation was wrapped up in 'The Ramsay Way' principles with the core message being around caring – 'People caring for people'.
- Staff were introduced to the vision and strategy during induction to the company. The key messages were advertised across the unit by way of posters and literature.
- Staff had taken part in bi-annual forums where vision and strategy focussed on what this meant for them.
- Senior staff revisited vision and strategic objectives as a standing agenda item at management meetings. Organisational and local strategy featured in recruitment, appraisals and objective setting.
- Managers reviewed the local strategy annually to ensure the organisational objectives were encompassed and embedded into TVTC business planning.
- At the heart of the local strategy were key themes around the importance of the team, 'Our People'. This was further underpinned by core elements within the business covering governance, service development, knowledge of local needs, effective operations and being cost-effective.
- TVTC developed a local clinical quality strategy based on four core elements – the Ramsay Way, the principles of the 6 C's, the five domains of the Care Quality Commission and a northern region corporate initiative.
- The key aims of the clinical strategy were to be recognised locally as the leading provider of outpatient day care services with high quality outcomes and excellent patient experience, getting it right first time by putting patient safety first, setting standards and measuring practice, attracting and engaging the best staff and emphasising the significance of everyone's contribution on patient care.
- The clinical strategy was advertised on the unit and staff were aware of the organisational priorities.
- All staff confirmed their commitment to 'The Ramsay Way' as they considered this synonymous with their own values of delivering high quality care. Staff told us they were proud to work at TVTC and for RHCUK.
- All RHCUK and TVTC marketing complied with the guidance provided by the Competition and Mergers Authority (CMA) and Advertising Standards Agency (ASA).

Governance, risk management and quality measurement

Good

Surgery

- The governance structures in place were simple, clear and effective. The general manager had oversight of a clear committee structure. This included the SMT, the HoDs, the health and safety committee and the MAC.
- The clinical governance committee (CGC) was fed by a number of operational sub-groups, namely the infection prevention and control committee, the medicines management group and the blood transfusion group.
- Minutes from each committee meeting were of a professional standard and gave a clear account of agenda items, actions and responsibilities. They were available and emailed to all staff. This supported the good open approach to monitoring and measuring quality and safety in surgery and across the hospital. The unit also displayed a 'policy of the month' for all staff to refresh their knowledge on a particular area.
- The service incident reporting system 'RiskMan' integrated local incidents and local risks into funnel graphs and performance reports to support risk management initiatives. Managers also considered assurance reports in relation to staffing, incidents, complaints, audit and practising privilege compliance.
- We had sight of the TVTC risk register. There were 17 risks identified across a range of nine categories – financial (7), patient safety and clinical care (3), facilities and equipment (2), health and safety (1), legal (1), environment (1), leadership and management (1) and communication and information (1). All risks were defined as local risks however all appeared to have a generic corporate agenda.
- We noted that all risks were opened in January 2014 and had a responsible staff member attached. Risks were rated as low, moderate or high. Only one risk had a residual rating of 'high' categorised under the financial heading. We observed that there was no rating tool used to measure likelihood or severity, and grading was measured as per Ramsay Health Care UK policy.
- The hospital management team had acknowledged the risk register should be improved to serve the local hospital need, and include clinical risks in greater detail when they exist. We were assured that senior management had identified their local risks for example, restrictions of capacity and use of agency staff in theatres, and these needed to be better reflected in the risk register. These risks were discussed in senior meetings. The provider should continue with ongoing plans to improve their current hospital risk register.
- Any financial considerations were reported as part of the governance framework. Managers confirmed financial matters did not appear to have an impact on the quality agenda or compromise quality of patient care.
- Procedures were in place to ensure surgeons with practising privileges had valid professional indemnity insurance. We reviewed staff files and found arrangements to be in place for all staff. The general manager in conjunction with MAC had a system to monitor the status of practising privileges, GMC registration and indemnity arrangements.
- TVTC published an annual quality account which detailed the centre statement on quality, priorities for improvement and a review of quality improvement. The report confirmed the clinical priorities for the coming year to be patient safety issues (improving care for any deteriorating patient, maintaining WHO checklist effectiveness, raising awareness around dementia care), improving the patient experience (satisfaction and recommendation rates) and clinical effectiveness (maintaining endoscopy standards).
- The service had submitted required data to the Private Healthcare Information Network (PHIN) ahead of the deadline imposed by the Competition and Markets Authority MIS Order. The service had also developed local procedures to collect and code all on-going private patient activity.
- The centre had a National Safety Standards for Invasive Procedures (NatSSIP) implementation action plan, policy and aligned SOP's. In November 2016, four of five of key areas for compliance has been completed (theatre standards training, revised theatre operating policy, visiting consultant communications and human factors training). The final element around a training programme roll out was in progress and due for completion in January 2017.

Leadership/culture of service related to this core service

- The service was led by a manager with oversight of the day unit and theatre. The service manager was supported by the site matron and general manager.
- There were recognised and well established lines of responsibility and accountability.
- The manager told us that her team fully supported the unit and recognised the valuable input into all aspects of the running of the department.

- The unit managers brought significant clinical and managerial experience to their roles. They recognised the challenges in meeting the organisational agenda and delivering quality care to meet local need.
- Staff we spoke with, without exception, stated the support from their managers to be very good. Managers were visible, approachable and available at all times. Staff considered managers to be integral to the team and recognised their encouragement to build strong supportive relationships with colleagues.
- Staff did not hesitate to raise concerns to managers and stated their views were actively sought and listened to. Staff felt their contribution was valued and respected.
- 'The Ramsay Way' underpinned the organisational and local culture at TVTC.
- There was a commonality in the organisational philosophy, local culture, departmental teams and individual staff values which truly focussed on taking pride in what they do, being caring, the value of integrity and credibility, building constructive relationships, recognising the value of the team and growing the business to ensure strong stakeholder loyalty.
- We observed professional and polite interactions between staff. There was a clear, palpable and embedded strength in team working throughout the unit.
- There was a strong emphasis on staff wellbeing which was especially evident from the managerial response to staff survey results.

Public and staff engagement

- TVTC actively sought patients' views and experiences on the care received. There was a variety of surveys and forums which provided the opportunity for patient's to comment on their journey.
- TVTC invited all patients to complete the NHS Family and Friends feedback and 'we value your opinion' comment cards. Additionally, the service offered on-line surveys and telephone feedback opportunities for patients. These were collated by an external research company who provided monthly summaries on content. The company also alerted TVTC immediately in the event of 'hot alerts' which staff referred to particular comments of concern or particular comments of praise.
- Results from patient experience surveys were consistently positive in all areas.
- There had been significant managerial input into staff engagement initiatives over the previous 12 months in response to staff survey findings. The 2015/16 'My Voice' findings triggered a number of actions to further improve staff morale and engagement. These actions covered topics such as blending engagement with non-clinical staff, staff engagement boards, improved communications, reinforcement of staff benefits, better rota management, improved accessibility to learning via the Ramsay Academy and the conception of a staff social group.
- Staff commented upon how morale was good and this was in part due to the real efforts of the management team to promote their wellbeing. Staff commented about the family Christmas party (where their children received presents), regional fun walks and greater engagement in local events. Staff were also recognised by the organisation for their work by way of the customer services award.
- TVTC actively supported a number of local, national and international charity events which staff were proud to be involved.
- Staff were particular enthusiastic to announce the confirmation of the new hospital to be built in the area. Staff considered this was a real commitment by the organisation to the region and recognition of their work. Staff had been on site visits and had planted a medical time capsule to mark the build.

Innovation, improvement and sustainability

- Staff at the centre were continuously looking at ways to improve the service by way of local service development or innovative practices.
- In response to a review of gynaecological services, the centre engaged with a female consultant gynaecologist who has now joined the team at TVTC. This appointment has proven popular with the local population and referrers.
- The centre has continued to review and flex opening hours to provide a sustainable service for patients. This had included extended weekday working and weekend theatre availability.
- TVTC consultants have held and hosted educational events for referrers on specialist topics such as urology, gastroenterology and orthopaedics. This strengthened working relationships with colleagues, improved patient pathways and provided valuable continuous professional development opportunities for local GPs.
- The centre had identified a number of oral surgery referrals lacked sufficiently detailed and accurate

information. The consultant oral surgeons created a bespoke referral form for referrers providing clear guidance on the information and data set required. This helped in dentist engagement and reduced administrative time wastage.

- In December 2016, following initiation of both environmental and awareness initiatives, TVTC was recognised as working towards being a dementia friendly unit by the Dementia Action Alliance.
- Ramsay Health Care UK approved the build of a new hospital for the people of Teesside and beyond which would see the current TVTC facility move to a purpose built centre in 2017/18.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- The provider had robust systems to report and investigate incidents. Clinical incidents were investigated through the Clinical Governance Committee and Medical Advisory Committee and we saw process to cascade lessons learnt and inform current practice in order to make improvements.
- Managers explained that all staff were provided with training of 'RiskMan' which was the provider's electronic incident reporting system, at induction.
- Staff demonstrated a good working knowledge of the system and said they could access the system easily. Staff were familiar with the incident reporting policy and gave examples when they have been required to use it.
- The services reported no never events from October 2015 to September 2016 within outpatients. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Within outpatients, the provider reported two clinical incidents and three non-clinical incidents during the reporting period of October 2015 to September 2016.
- We reviewed a root cause analysis investigation report (RCA) following one reported incident within the outpatients department. The report contained a detailed 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.
- Staff were aware of the principles of duty of candour (DoC). The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person.
- Managers told us 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.
- Incidents were discussed within clinical governance committee meetings and we saw examples of this within the minutes.
- A manager told us that the matron regularly attends the Northern Regional Matrons group to share and learn from incidents.
- We saw following a particular incident within outpatients, that lessons were learnt and staff practice was reviewed and changed as a result of this.

Cleanliness, infection control and hygiene

- During the reporting period of October 2015 to September 2016 there were no incidences of

Clostridium Difficile (C.Diff), no incidence of Methicillin-resistant Staphylococcus Aureus (MRSA) or Methicillin-sensitive Staphylococcus Aureus (MSSA) throughout all services provided.

- Outpatient areas were visibly clean and clutter-free. Policies and procedures for the prevention and control of infection were in place.
- Staff understood them and could describe their role in managing and preventing the spread of infection.
- The infection control lead nurse carried out regular handwashing and environmental audits. This was part of the hospital wide infection control audits and which monitored compliance with key hospital policies such as hand hygiene. We saw that handwashing audits completed in November 2016 achieved a compliance score of 97% and December 100%. An environmental audit completed in November 2016 achieved an overall compliance score of 91% with clear actions identified to enable this score to improve.
- Results were shared at infection control meetings and shared with staff.
- Personal protective equipment (PPE) such as gloves and aprons was used correctly and available for use in the departments.Once used it was disposed of safely and correctly.We saw PPE being worn when staff were treating patients and during cleaning or decontamination of equipment or areas. All areas had stocks of hand gel and paper towels.
- We saw all consulting rooms had handwashing facilities.
- The provider participated in the Patient-Led Assessments for the Care Environment (PLACE) scores for cleanliness showed 98% during the period of February 2016 to June 2016 showed a score of 98% for the hospital. Overall, the hospital scored the same or better than the England average for cleanliness (98%).
- Patient waiting areas, including toilets, and were clean and tidy.
- Staff mandatory training compliance regarding infection control showed 100% compliance for all clinical staff on the mandatory training matrix dated October 2016.

Environment and equipment

- The environment in outpatient areas was uncluttered and well maintained.
- Equipment within the outpatients department was calibrated and maintained as part of a maintenance contract.
- A resuscitation trolley was located upstairs in the ward. Staff told us that there was easy access to this equipment. All equipment including suction and oxygen lines were checked and found to be in date.
- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments.
- There was an appropriate secure storage area for waste and clinical specimens and we saw that this was well organised and free of clutter.
- We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained.
- We found that electrical equipment testing and calibration stickers were in place on fridges and scales.
- The reception area of the outpatients department was light and airy. The department was small and the area felt compact, however staff were friendly and personable which promoted a friendly and open environment.
- We saw, and staff confirmed that, there was enough equipment to meet the needs of patients within the outpatients departments.
- Specific equipment required such as bariatric chairs were situated on the ward. All transfer trolleys accommodated bariatric patients.
- Results from PLACE audit in June 2015 and local environmental audits were good. In the PLACE audit the condition appearance and maintenance scored 95% against the England average of 93%.

Medicines

- All medicines were supplied, stored, prescribed, administered and disposed of in line with Ramsay Health Care UK and TVTC policy and procedures. Pharmacy services were outsourced to local provider, and a designated member of staff had responsibility for liaison and management of stored medicines, audit and staff training.
- Medicines in the departments were stored and monitored appropriately. Medicines were kept in locked cabinets and we saw evidence that daily temperature checks of medication fridges and the ambient room temperature were recorded. These were all in appropriate temperature ranges.
- A prescription pad was located within the ward area and was kept in a locked drawer. Nurses were able to sign to collect the pad and return it for those consultants wishing to prescribe medication

Good

Outpatients and diagnostic imaging

- Staff ensured medicines that required refrigeration were stored within safe temperature ranges. We saw that fridge temperature checks were completed on a daily basis.
- No controlled drugs were stored within the outpatient departments.
- Medicines management was audited by the pharmacy service, which completed six-monthly audits. These included accuracy of documentation, medicine administration, safety and secure storage checks. We reviewed the audit completed for June 2016 and saw that 96% compliance was achieved. This was an improvement from the previous audit which achieved 86% in April 2016.

Records

- Records in the outpatient department were a combination of paper and electronic information, which contained specific information regarding the patients past medical history.
- The full medical records for both NHS and private patients remained on site.
- At the time of inspection we saw patient personal information and medical records were managed safely and securely.
- We reviewed 10 sets of medical records across the outpatient department. They contained sufficient up to date information about patients including referral letters, medical and nursing notes including patient care pathways, operation and anaesthetic records and discharge documentation.
- The provider completed medical records audits against professional standards and Ramsay Health Care UK policy. We reviewed the audit carried out in July 2016 which achieved 96% compliance. A clear action plan was completed to enable an improved score.
- Whilst the clinic was running, patients' notes were stored in in lockable cabinets. At all other times, patients' records were stored in lockable storage rooms. Paper records were stored alongside NHS records but were managed separately.
- Staff told us all patients attending an outpatient appointment would have available either an accompanying GP referral letter, or their current records from a previous appointment or admission to the hospital.
- Staff told us that if patient information or paperwork were missing, the staff took a proactive approach by obtaining the data from either the patient or consultant in advance of an appointment.
- The hospital had a policy in place that consultants were prohibited from taking patient medical records out of the hospital, with the exception of private patients where they are permitted to take a copy of the consultation and operation record for their private practice administration. If a consultant took patient identifiable data out of the hospital, the consultant must take adequate steps to protect the information and be registered with the Information Commissioner's Office (ICO). All consultants are requested to register with ICO when they apply for practising privileges, if appropriate. Review of practising privilege agreements confirmed this.

Safeguarding

- There were no safeguarding concerns related to the outpatients department from October 2015 to the time of our inspection.
- All staff we spoke with were fully aware of safeguarding policies and procedures and felt confident when raising concerns. Staff told us they were able to seek advice from their manager when needed.
- Policies and procedures were available on the intranet and staff were able to demonstrate how to access them.
- Patients who did not attend appointments were contacted via telephone and referrers were informed.
- The matron was also the designated lead for safeguarding and had completed level three adult safeguarding training.
- The Ramsey Health Care Mandatory training matrix for October 2016 showed 100% compliance for level 1 vulnerable adults training and 100% for level 1 safeguarding children. Safeguarding training was mandatory for all staff.

Mandatory training

- Mandatory training was available via on-line courses as well as face-to-face training.
- Staff told us they were provided with adequate time to complete all aspects of their training.
- We saw a robust induction programme for all staff which included on-going support from an experienced mentor.

Good

Outpatients and diagnostic imaging

- At the time of our inspection 100% of outpatient staff had completed all the required mandatory training. This included Health and Safety, Infection Control, Manual Handling, Prevent, Customer Service, Information security and Equality and Diversity.
- 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

- There were emergency call bells in all of the outpatient consulting rooms. Staff told us that that an additional alarm at the reception desk could be activated with a fob key which would also alert staff upstairs on the ward area.
- We saw that there was a process in place for managing patients who were deteriorating. This included firstly contacting the employed doctor available on that day, involving the patient's consultant and transferring the patient to the Accident and Emergency department of the local NHS hospital. There were test scenarios run in collaboration with by South Tees NHS trust and North East Ambulance Service and this was being performed the week after inspection.
- Nurses from the ward area would attend the outpatient department upon activation of the emergency call bell. The resus trolley from the ward would be brought down. Staff advised that they would contact the emergency services should the patient decline rapidly.
- There was a named radiation protection supervisor to ensure the mini C Arm in theatre complied with the Ionising Radiation (Medical Exposure) 2000 Regulations. We saw that routine checks were in place and all documentation was fully completed.
- Policy and processes were in place to deal with radiation risks. This was in accordance with (IR(ME)R 2000)

Nursing and care assistant staffing

- We looked at the staffing levels within the outpatient department. Staffing levels were planned in accordance with the number of clinics operating on each day and the nature of the clinics. For example we saw during our inspection that an additional nurse was present to assist with patient pre-assessments.
- The outpatient department had a team of one registered nurse, two healthcare assistants, receptionists and administration staff. The staff provided clinic cover Monday to Friday, generally from 7:30am to 8:00pm, with a morning clinic held on a Saturday. This varied to accommodate specific patient requests and consultant working arrangements.
- Staff in the outpatients department told us that workload varied depending upon the number of clinics and the number of patients attending.
- A lead nurse managed outpatients and divided the clinical time between the ward and the outpatient department. Staff told us that the lead nurse was very supportive and always available for advice.
- The service used no agency nurses and had bank staff to cover specialist clinics if required.
- Ward staff regularly rotated to enable them to gain experience of working with the outpatient department.
- There were no vacancies within the nursing and health care assistant staff in the outpatient department at the time of inspection.
- There was no sickness for outpatient staff during the period of October 2015 to September 2016.

Medical staffing

- Consultants were employed under the Ramsay Health Care UK practising privileges policy. All consultant staff provided the organisation with standard information showing that they fulfilled the criteria for employment. There were 43 consultant staff with practising privileges. The senior manager held information for every consultant.
- Three medical staff were also solely employed by the TVTC and also covered any on call enquiries from patients if required.
- Consultants were required to cross cover within the same speciality or sub-speciality.

Major incident awareness and training

- The hospital had an overarching business continuity policy put in place by the wider Ramsay Health Care UK group.
- Staff we spoke with were aware of the major incident policy and could describe how they would access this in an emergency.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective:

Evidence-based care and treatment

- Care and treatment within the outpatient department was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as NICE.
- We saw examples of policies which are referenced against best practice guidance. For example, the chaperone policy referred to professional guidance from the Royal College of Nursing (Chaperoning: The role of the nurse and the rights of patients, (2006) and the GMC (2013) and the safeguarding policy referred to national guidance (Safeguarding Adults: The role of Health Services, Department of Health, 2011).
- The pre-assessment process which was managed by the outpatient team had also adopted the new NICE guidance following review from the consultant anaesthetist.
- Patients' needs were assessed according to their physical, clinical and mental health.
- Discrimination on grounds of age, disability, gender, gender reassignment, race, religion or belief and sexual orientation was not a factor when considering care and treatment decisions.
- Data was regularly submitted contributed to the private healthcare information network (PHIN) as part of benchmarking its practice.

Pain relief

- There was a process in place to enable patients attending the outpatient department to access pain medication.
- We reviewed medication stored within the outpatient department and saw that patients were provided with analgesia should they require it.
- Patients we spoke with during the inspection had not needed pain relief during their attendance at the outpatient department.
- The online patient surveys asks patients 'did staff do everything they could to control pain'. The results for the most recent survey in 2016 showed 100% compliance overall for the treatment centre.

Nutrition and hydration

- The department provided a cold water dispensing machine within the waiting area, and hot drinks were provided if requested.

Patient outcomes

- From October 2015 to September 2016 the hospital outpatient department saw 19,730 patients. Of these, 8918 were new appointments and 10,812 were follow-up appointments.
- The hospital compared survey results and activity with other locations within the region and other regions across locations in the Ramsay Health Care UK group.
- TVTC reported participation in positive patient feedback and monitoring of variances in care pathways as part of overall monitoring of patient outcomes.
- As part of the above programme of audits we saw that the provider completed pre-admission and discharge planning audits. We reviewed the audit results for September 2016 and saw that the average score was 96%.
- A senior manager told us that the numbers of cancelled appointments were low. We reviewed data submitted by the provider, which showed that no appointments were cancelled on the day of consultation during the period of October 2015 to September 2016.

Competent staff

- We saw that all staff completed a robust induction programme before commencing their role. New staff were supported by a mentor and we saw regular communication between new staff and their managers.
- Nurses were supported with revalidation and several support sessions had been provided by the general manager to guide staff through the process.
- Staff told us they were supported to maintain continuous professional development develop new skills. For example a nurse told us they were shadowing another colleague within the theatre department to gain an understanding of this role.
- All department leads completed lead nurse training as part of an internal training programme.

Good

Outpatients and diagnostic imaging

- All staff we spoke with had received a formal annual appraisal and mid-term appraisal every six months. We reviewed an appraisal compliance audit that confirmed 100% of staff had undergone an annual appraisal in this service.
- Appraisals and mid-term objectives were linked to the hospital vision and values and the Ramsey strategy. Staff told us personal objectives were encouraged and supported.
- Medical appraisal was carried out at the main employing NHS trust for consultants with practicing privileges 100% of these were up to date. There was a process in place to ensure all consultants were up to date with the revalidation process.
- All nurses completed a structured competency programme. We checked six staff files and saw that all competencies were complete and up to date.
- There was a 100% validation of professional registration for nurses working in the department.
- Staff had recently received training from The Alzheimer's Society regarding dementia care and several staff we spoke with had become dementia friends.

Multidisciplinary working (related to this core service)

- All clinical and non-clinical staff we spoke with told us the team worked well together and enjoyed the busy working environment.
- Staff based within the ward area often rotated to provide cover to the outpatients department and gain additional skills whilst working in this area. Staff told us they enjoyed the rotation and the chance to see patients from first referral to care and treatment on the ward.
- Many of the staff had worked with the provider for several years and had strong relationships with professional referrers and NHS colleagues. Staff told us they felt this improved the patient experience and supported timely care.
- The general manager and matron held good relationships with local trusts and commissioners.
- TVTC had a service level agreement (SLA) with a local provider to deliver physiotherapy care and treatment to patients when required.

Access to information

- We saw that staff had access to policies and procedures through the Ramsay Health UK group intranet. NICE guidance and e-learning modules were available.
- Patient records were in paper format. Staff told us that records were brought to clinic in advance of the patient appointments. Missing records were not common but we saw procedures if patient records were not available at the time of appointment. Staff had access to previous clinic letters electronically.
- The hospital shared relevant information with the patients GP and accessed specialist advice from local trust professionals regarding conditions such as dementia and learning difficulties.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with had a good understanding of issues in relation to capacity and the impact on patient consent. We saw staff received mandatory training and were able to explain how they gained consent for care and treatment.
- Senior staff in the department demonstrated understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards.
- Ramsay Health Care UK had corporate policies to guide practice in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- All staff had received training on MCA and DoLS as part of online level two safeguarding mandatory training.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- We observed staff within the outpatients department. Staff at all times were caring and compassionate to patients.
- Although the reception area was very small and staff talking on the telephones could be heard, there were additional rooms available should patients need to speak to staff in private.
- All patients we spoke with told us that staff were very kind and spoke with them in a caring manner. They told us that staff had respected their privacy and dignity when delivering care.

Good

Outpatients and diagnostic imaging

- Staff spoke with pride about 'The Ramsay Way'. This placed care and compassion at the centre of everything that staff do.
- Clinic names were not displayed in to order to maintain patient's privacy and dignity.
- The hospital supported the 6Cs initiative. The 6Cs is a national initiative to promote care, compassion, competence, communication, courage and commitment.
- In the same survey patients were asked 'how satisfied they were with the doctors and nurses during their visit. 98% was recorded for nurses and 94% for doctors.
- The hospital recorded family and friends test scores. From April 2016 to September 2016 the provider recorded 100% for all scores overall in the treatment centre.
- The hospital had a policy in place concerning the use of chaperones. This provided guidance on chaperones, their availability to patients, and that the patient would have the option to reschedule an appointment if a chaperone was not available. We saw chaperones were available in the departments we visited and had received training to support this.
- We saw patients and staff had a good rapport with staff putting patients at ease. Some patients were regular attenders and knew the staff well. A patient told us 'This is my second treatment here. The staff are wonderful. I never have to wait for anything. They really look after me'. Staff told us that families were invited into the consulting room as long as the patient was agreeable.
- We observed doctors coming out to meet their next patient due into their clinics and introducing themselves to them before helping them to the consultation room. When available, nurses would escort patients from reception to the consulting rooms.

Understanding and involvement of patients and those close to them

- Patients were provided with guidance regarding their treatment and care. We observed a member of staff explaining fasting arrangements as part of the pre-admission assessment.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.
- All of the 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 were given time to make decisions and staff had made sure they understood the treatment options available to them.

Emotional support

- We saw staff spend time talking to patients and showing empathy and encouragement to complete aspects of therapy.
- Cosmetic surgery procedures were available and a consultant told us that 'time is taken to ensure patients expectations are realistic'. Access to psychology services was available for those patients who would require them.
- There was access to a counselling service.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Staff within the outpatients department worked flexibly to meet capacity demands. We saw that an additional nurse was allocated to the department from the ward to assist whilst pre-admission assessments appointments were held.
- The service provided 99% of surgical treatment to NHS patients and 1% to other funded patients. The hospital engaged with the local Clinical Commissioning Group on a bi-monthly basis to plan and deliver contracted services based on local commissioning requirements.
- There was a range of outpatient clinics offered including services such as a variety of surgical specialties, endoscopy, dermatology, and plastic surgery.
- Digital dictation was used by the consultants within the department to enable a swift turnaround for letters and appointments.
- Clinics tended to run in a predictable pattern and the busier time periods were staffed accordingly.
- Plans were in place to develop a purpose built provider owned hospital in a nearby area, which would support the increase in referral numbers.

Good

Outpatients and diagnostic imaging

Access and flow

- Referral to treatment times (RTT) were all better than national targets. RTT waiting times for outpatients was 100% for non-admitted pathways from October 2015 to April 2016. May reported a slight decrease to 99%; however 100% was consistently achieved up to the point of inspection.
- Appointment times for patients were staggered in order to reduce waiting times. Patients told us 'I am always seen quickly. I much prefer to come here'.
- The hospital did not formally advertise waiting times in waiting areas; reception and nursing staff monitored these remotely. During inspection we saw that clinic times were met and there were no delays.
- We saw that appointment times were booked around the needs of the patient. Requests to re-arrange appointments due to personal circumstances were accommodated.
- Staff in outpatient clinics told us that there was no restriction on the number of appointment numbers within the department. The department would flex to manage the numbers on a weekly basis.
- Staff told us there would be a number of occasions when clinic would need to be cancelled, although this was infrequent. The treatment centre did not monitor these cancelled clinics; however we saw a policy was in place whereby consultants gave six-weeks' notice if a clinic needed to be cancelled. Where clinics were to be cancelled the consultant would clinically review all of their follow up patients in that clinic to ensure the delay in their appointment would not compromise their care and pathway. Cancelled appointments were also monitored as part of the consultants practice and privileges.
- Patients told us they 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.

Meeting people's individual needs

- All patients were asked to complete a medical health questionnaire prior to undergoing any treatment or procedure. Health questionnaires were checked by administration staff and referred to the nurse should the patient have identified any issues. Conditions such as high blood pressure, epilepsy, stroke etc. would require the patient to visit the clinic for a pre-admission assessment.
- Consent from the patient was obtained at this point to contact the appropriate GP to confirm suitability for treatment.
- We observed an assessment and saw that a thorough medical history was obtained, alongside blood pressure monitoring, blood sample, MRSA swabs and understanding of the treatment or procedure.
- Staff told us they were able to access interpreting and translation services if they needed to. However, staff we spoke with identified this was rarely required.
- We saw patients were provided with a range of information leaflets specific to their treatment including physiotherapy and exercise regimes.
- The hospital dementia rating in the PLACE audit of February 2016 to June 2016 was lower than England average (75% compared to the national average 81%). Staff had recently received training since these scores, from The Alzheimer's Society in relation to caring for patients with dementia. Staff told us the training was extremely helpful and educational and felt they were well equipped to support individuals with this condition.
- Staff told us they could access specific advice regarding patients with a learning disability when providing care for patients with learning disabilities. Online guidance was available to staff and staff told us it was easily accessible.
- The patient waiting area was tidy with sufficient comfortable seating for patients visiting the department. There was access to water, books and magazines for patients who were waiting.
- The department was located on the ground floor and there were toilet facilities available for patients, including toilets with disabled access within the hospital. Although the reception area was small there was sufficient space to manoeuvre a wheelchair.
- There was no on-site facility to engage in religious activity.
- The hospital provided free parking on-site, which was extremely busy. We saw that some patients found it difficult to obtain a car parking space; however, reception staff reassured patients that their appointment time would be maintained whilst they found a parking space.

Good

Outpatients and diagnostic imaging

Learning from complaints and concerns

- The hospital had a complaint policy in place and the overall management of complaints sat with the general manager.
- The hospital received 12 complaints during the period from October 2015 to September 2016. One of these related to a patient with dementia and the patient journey throughout the care provided at the treatment centre. We saw clear lessons were learnt and changes in practices occurred as a result of complaints.
- Staff were aware of the complaints procedure and felt confident raising concerns as they arose.
- We saw that lessons were learnt as a result of complaints investigations. We reviewed one complaint regarding a patient with dementia needs, which saw the introduction of training for all staff within the hospital.
- Staff described how they would resolve patients' concerns informally in the first instance, but would escalate to senior staff if necessary.
- Staff told us that complaints and comments were reviewed and discussed by teams at monthly staff meetings.
- Leaflets were available for patients in the waiting area, which provided details of how to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- The Ramsay Health Care UK corporate vision and strategy values in 2016/17 was focussed on patient focused care, cost effectiveness, engagement with stakeholders, valuing staff, delivering quality care and multidisciplinary working.
- A senior manager told us a company quality goal was 'Get it right first time'.
- Staff spoke with pride about the 'Ramsay Way' vision and this was embedded in the care and culture of the staff. The objectives for the outpatient department were aligned to hospitals values, including for example aiming to provide compassionate care to patients.
- Staff were invited twice a year to staff forums which were chaired by the general manager and 'set the scene' for the year ahead.
- The 'Ramsay' values were embedded into the appraisal process for staff and recognised behaviours were expected of them. All staff we spoke with told us that patients were placed at the heart of everything that they do.

Governance, risk management and quality measurement for this core service

- We saw governance structures were robust, clear in structure and had effective steam lined processes to communicate decisions with staff.
- Clinical governance meetings were held monthly and were attended by the heads of department. These meetings fed into the medical advisory committee (MAC) and hospital management team. We reviewed the minutes of these meetings are saw that they were comprehensive and covered issues such as incidents, clinical guidelines, referral rates and complaints.
- We reviewed the hospital risk register and there were 17 risks identified across a range of nine categories. Risks were discussed in the governance meetings. Staff told us that risks were discussed and actions from governance meetings were shared at team meetings and we saw evidence of this from staff team meeting minutes.
- We reviewed local team meetings minutes and saw that action plans and areas for improvement were clear following incidents.
- We noted a structured audit calendar for planned audits. We saw evidence of regular audit activity and action plans where improvements were required.
- Senior managers told us they took a 'ward to board approach'.

Leadership of the service

- All staff we spoke with described managers as approachable and effective. There was strong leadership of the service and managers had an open door policy.
- The leadership structure was clear and all staff we spoke with were supported clinically by the department heads.
- We saw that staff had positive working relationships and staff told us they received support from all grades of management.

Good

Outpatients and diagnostic imaging

- Clinical governance meetings were held monthly and were attended by the heads of department. These meetings fed into the medical advisory committee (MAC) and hospital management team.
- Staff felt there was a positive working culture and they were passionate about their patients and the standards of services that they provide.
- Staff told us they were actively encouraged to identify training needs, in addition to the mandatory training programme. Several staff gave us examples of courses they had identified and were supported to attend.

Culture within the service

- All staff we spoke with felt proud to work for the organisation. Staff told us that there was a strong sense of team work and everyone 'pulled together'.
- Managers encouraged an open and transparent culture and staff were encouraged to report incidents and complaints. A member of staff told us that complaints were rare in the department and 'everyone ensured problems were put right'.
- Staff told us they were excited about the prospect of a new unit being built in the near future and were open to ideas and change.
- Vacancy rates were extremely low. Retention of staff was good.
- We observed communication between staff and saw that is was friendly, open and supportive.

Public and staff engagement

- Patients were encouraged to complete an online patient satisfaction survey which asks patients about varies aspects of their care and treatment. There were in addition collection boxes for patient satisfaction surveys throughout the treatment centre or they could be returned by post. The results from surveys were analysed by an independent third party and communicated back to the hospital on a monthly basis for learning and action.
- The general manager and matron receive 'hot alerts' on a weekly basis from patients who have identified that they wish to make additional comments about the treatment centre.
- Patients are also encouraged to complete the friends and family test and results were shared with all staff within the centre. The hospitals Friends and Family Test scores were 100% across the period of April 2016 to September 2016.
- Posters were displayed on walls asking patients to complete 'how are we doing' cards.
- The hospital had a monthly 'magic moments' recognition awards system. Staff nominated each other in recognition of going above and beyond in their day-to-day work. Winners were selected by the hospital management team and received a prize.
- A senior manager told us that a competition was to be held in which staff could suggest a name for the new unit to be built. There would be a small prize for the winner.
- Staff told us that a member of staff suggested that a time capsule be buried at the new site containing health care memorabilia. We saw that this suggestion was implemented as part of the build.
- Local GPs were sent regular newsletters and updates, and information packs containing details about the hospital and how to refer patients to the hospital.

Innovation, improvement and sustainability

- The Ramsay Health Care UK Group was building a new day-case unit within a nearby local area, which would support the expansion of services which the current treatment centre offered.
- We saw that the group reviewed the company strategy each year to reflect the local commissioning needs.
- TVTC had access to an electronic tool in which staff could view the most recent biochemistry and haematology results completed in primary and secondary care. This allowed blood results to be viewed quickly and avoids unnecessary repeat sampling.

Outstanding practice and areas for improvement

Outstanding practice

- Staff involvement in public engagement and local community was to be commended as a team, with examples such as annual Christmas parties, Macmillan coffee mornings, working with the Samaritans' 'shoebox' campaign.
- In response to a review of gynaecological services, the centre engaged with a female consultant gynaecologist who has now joined the team at TVTC. This appointment has proven popular with the local population and referrers.
- TVTC consultants have held and hosted educational events for referrers on specialist topics such as urology, gastroenterology and orthopaedics. This strengthened working relationships with colleagues, improved patient pathways and provided valuable continuous professional development opportunities for local GPs.
- The centre had identified a number of oral surgery referrals lacked sufficiently detailed and accurate information. The consultant oral surgeons created a bespoke referral form for referrers providing clear guidance on the information and data set required. This helped in dentist engagement and reduced administrative time wastage.
- In December 2016, following initiation of both environmental and awareness initiatives, TVTC was recognised as working towards being a dementia friendly unit by the Dementia Action Alliance.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should meet the duty of candour Ramsay Health Care Policy requirements and the full legal process, specifically in terms of meeting 10 day timescales to respond in writing to patients. The hospital met the ethos of duty of candour in terms of apologising to patients when a serious incident occurred and providing an explanation.
- The provider should continue with audit and improvement work to improve staff compliance and consistency of completion of National Early Warning Score (NEWS).
- The provider should develop the local and corporate risk register to ensure all clinical and local risks to service are captured fully.
- The provider should continue to monitor the attendance of theatre staff to mandatory training to ensure the action plan is fulfilled and compliance is met for 2016/2017.