Nuffield Health York Hospital

Quality Report

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Date of inspection visit: 6, 7 and 13 September 2016
Date of publication: 14/06/2017

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health York Hospital is operated by Nuffield Health. The hospital has 40 beds and facilities include three operating theatres (two of which have laminar flow), a surgical unit for ambulatory care, radiology, outpatient and diagnostic facilities. The hospital provides surgery and outpatients with diagnostic imaging services and we inspected both of these services.

We inspected this hospital using our comprehensive inspection methodology. We carried out the announced part of the inspection on the 6th and 7th September 2016 with an unannounced visit to the hospital on 13th September 2016.

We rated both core services and the hospital as good overall.

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

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

Services we rate

We rated this hospital as good overall because:

- There were systems and processes in place to promote practices that protected patients from the risk of harm. Openness and transparency about safety were encouraged. When something went wrong, people received an explanation, and a sincere and timely apology.
- There were sufficient and appropriately qualified and experienced staff working in all departments to meet the needs of patients. We saw that equipment in all areas was well maintained and kept clean to minimise the risk of infection. Staff were able to respond to signs of a deteriorating patient and medical emergencies.
- Patient feedback demonstrated that staff strived to make the patient experience as positive as possible. Staff recognised and responded to the individual needs of their patients throughout the patient journey.
- The hospital had systems in place to provide care and treatment in line with national guidance. There was effective multi-disciplinary working and good communication between teams within the hospital and with external healthcare partners.
- There was a stable leadership team who were highly regarded by staff. Staff felt proud to work within the hospital and were very positive about the culture and the quality of teamwork.
- There was a clear governance structure and a comprehensive reporting framework in place that provided timely information to the hospital board, medical advisory committee and to the corporate team.

We found areas of practice that required improvement in both surgery and outpatients services.

- We did not identify a clear mechanism to share learning from unplanned transfers and patient safety incidents with the Resident Medical; Officer. This was acted upon at the time of inspection and at the unannounced inspection, communication systems had been improved.

In surgery:

- None of the ten surgical case notes reviewed for consultant entries recorded daily consultant visits as per the requirements of practising privileges. Two sets of notes had documentation about the consultant's visit from the nurse in charge of the patient's care.

Summary of findings

- Two patients receiving oxygen did not have oxygen prescribed on the medication record. This was raised at the time of inspection and immediately actioned.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good overall because it was safe, effective, caring, responsive and well-led. The service had reported no never events or serious injuries. Learning was cascaded via the governance committees and received at staff team meetings. Internal patient satisfaction surveys indicated 96% satisfaction for cleanliness and the service had a low rate of hospital acquired infection. The hospital target for mandatory training completion was 100% compliance; training data we reviewed showed a compliance rate of 95% at the beginning of September 2016. Integrated care records covered the entire patient pathway from pre-operative assessment to discharge and included comprehensive care plans for identified care needs. We reviewed 25 sets of medical and nursing care records whilst on site and records were legible, complete and contemporaneous. Staffing was reviewed on a daily basis for the forthcoming shifts and adjusted according to clinical need and theatre activity. A weekly capacity meeting was held each Thursday morning to review the following week's activity and staffing levels. The hospital had an out-of-hours rota for anaesthetists to provide 24-hour cover for patients post-operatively and there was a service level agreement (SLA) for emergency transfer arrangements with the local NHS trust. The rate of unplanned transfers of care from this hospital to a nearby NHS trust, unplanned readmissions and unplanned returns to theatre was similar to or better when compared to independent hospital performance data held by CQC. Staff told us they had been supported with personal development through attending degree-based training programmes, national vocational qualifications and care certificate programmes.

Summary of findings

During the inspection, we observed warm, open and positive interactions between staff and patients. All patients we spoke with were happy with the care they received and we received universally positive written feedback from patients during the inspection.
The hospital achieved the overall referral to treatment indicators of 90% of NHS patients admitted for treatment from a waiting list within 18 weeks for the reporting period. It also achieved better than the indicator of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral in the reporting period.
A dementia "champion" provided additional support and training for staff on the inpatient ward. Patient-led assessments of the care environment (PLACE) scoring for the hospital showed dementia assessment as scoring 85%, which was better than the England average of 81%.
Inpatients had access to physiotherapy sessions several times a day, which allowed for quicker mobility and shorter stays in hospital.
In the last 12 months, the hospital cancelled 28 procedures. All patients received another appointment within the next 28 days.
The inpatient ward and theatres had regular staff meetings. We noted good attendance and discussion of key items such as the risk register, audit outcomes, complaints, incidents and infection control.
However:
We did not identify a clear mechanism to share learning from unplanned transfers and patient safety incidents with the RMO. This was acted upon at the time of inspection and at the unannounced inspection, communication systems had been improved.
None of the ten surgical case notes reviewed for consultant entries recorded daily consultant visits as per the requirements of practising privileges. Two sets of notes had documentation about the consultant's visit from the nurse in charge of the patient's care.
We saw that checks were made to ensure patients had adhered to fasting times before surgery went ahead; however, at the time of the inspection, the hospital did not undertake audits of actual fasting times and whether these met the expected standard.
Two patients receiving oxygen did not have oxygen prescribed on the medication record.

Summary of findings

We noted that patient specific directives (PSD) for bowel preparation did not always evidence that the patient had been assessed by the prescriber before it was supplied.

Outpatients and diagnostic imaging

Good

We rated this service as good because it was safe, caring, responsive and well-led. We did not rate effective as we are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

The service had reported no never events or serious incidents and no incidents had been reported to the CQC in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Staff were encouraged to raise concerns and report incidents. We saw evidence of lessons learnt from safety incidents and changes to clinical practice.

Medications including contrast media used in radiology were stored securely in appropriately locked rooms and fridges. There was an effective process in place for monitoring the use of prescription charts.

Policies and procedures were accessible to staff and had been developed and referenced to the National Institute for Health and Care Excellence (NICE) and national guidance.

All staff had completed an appraisal and they described being supported in undertaking further learning to develop their skills and knowledge.

All patients spoke positively about the care and treatment they had received and we observed staff acting in a compassionate manner. Patients were treated with dignity and respect. Patients were given appropriate information and support about their care or treatment.

The service was responsive to patients' needs. Access and flow in the Outpatient department (OPD) and radiology departments was well managed. Patients could be seen quickly for urgent appointments if required and patients told us their appointments were on time. Patient records were available for appointments and the department had timely access to test results.

People using the service could raise concerns and complaints were investigated and responded to in a timely manner.

Summary of findings

Contents

Good

Nuffield Health York Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Nuffield Health York Hospital

Nuffield Health York Hospital is operated by Nuffield Health. The hospital opened on its current site in December 2004. It is a private hospital in the city of York and primarily serves the communities of York and the surrounding area. It also accepts patient referrals from outside this area.

The hospital provides a range of surgical, outpatient and diagnostic imaging services to NHS and other funded (insured and self-pay) patients and works predominantly with consultants from the local NHS hospital.

The hospital director is the registered manager and controlled drugs accountable officer and has been in post since November 2009.

Outpatient services include dermatology, rheumatology, orthopaedics, urology, cosmetic surgery and cardiology. The outpatient department consists of 12 consulting rooms. The hospital provides an outpatient physiotherapy service in a dedicated department and has four treatment rooms and a gymnasium. The hospital also provides a range of diagnostic imaging services including X-ray, mammography, fluoroscopy, bone mineral density scanning and ultrasound. The service had a fixed site MRI scanner and a mobile CT scanner.

Inpatient and day case surgical services include endoscopy, orthopaedic, ophthalmology, gynaecology, urology, spinal, vascular, ear, nose and throat and cosmetic surgery. The hospital has one ward and a surgical unit for day cases.

The hospital provides consultation-only outpatient services for children 15 years and below and full services to 16 and 17 year olds in accordance with policy as part of their adult services.

The hospital is registered to provide the following regulated activities:

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

The inspection did not include the family planning service.

Our inspection team

The team that inspected the service included CQC lead inspector, Imogen Hall and CQC inspectors and specialist advisors with expertise in radiology, outpatient services, surgical and operating theatre nursing and clinical surgery. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Information about Nuffield Health York Hospital

We inspected two core services at the hospital; these were surgery and outpatient and diagnostic services. We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We requested information from the local clinical commissioning group. We placed comment boxes at the hospital before our inspection, which enabled patients to provide us with their views. We received 54 comments from patients.

We held two focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee. We spoke with a wide range of staff, including nurses, the resident medical

Summary of this inspection

officer, radiographers and administrative and support staff totalling 48 personnel. We also spoke with 24 patients at the hospital. We observed care in the outpatient and imaging departments, in operating theatres and on the wards and we reviewed 34 patient records. We visited all the clinical areas at the hospital.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected three times in the past and the most recent inspection took place in December 2014. This inspection found that the hospital met the standards of quality and safety that were inspected.

Activity (April 2015 to March 2016)

In the reporting period:

- There were 1,018 inpatient admissions, 2,582 day case admissions and 3,600 visits to theatre. Of these, 33% were NHS funded and 67% were other funded (insured and self-pay).
- There were 18,142 outpatient total attendances in the reporting period; of these 76% were other funded and 24% were NHS-funded.

Staffing

- 132 consultants including surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Two resident medical officers (RMO) worked on an alternate weekly rota. The hospital employed 29 whole time equivalent (WTE) registered nurses, 17.5 WTE care assistants and operating department practitioners and 52 WTE other staff, as well as having its own bank staff.

Track record on safety (April 2015 to March 2016)

- No never events.
- No serious incidents.
- There were 192 non-clinical incidents and 153 clinical incidents of which 97 caused no harm, 43 low harm, 12 moderate harm and none caused severe harm. There was one death (following post-operative transfer to an NHS trust).
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),Methicillin-sensitive staphylococcus aureus (MSSA) or Clostridium difficile (C.diff).
- One incident of hospital acquired E-Coli.
- One unplanned return to the operating theatre.
- Two unplanned readmissions.
- 10 unplanned transfers to an NHS hospital.
- During the reporting period, we did not receive any direct complaints or whistle-blowing contacts for Nuffield Health York Hospital. The hospital received 12 complaints in the same period.

Services provided at the hospital under service level agreement:

- Catering
- Facilities maintenance
- Pathology
- Waste collection
- Maintenance of medical equipment
- Breast care nursing
- RMO provision

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 systems for the reporting and investigation of safety incidents that were well understood by staff.
- Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.
- Internal patient satisfaction surveys indicated 96% satisfaction for cleanliness and the service had a low rate of hospital acquired infection.
- There were arrangements to transfer patients whose care needs exceeded what the hospital could safely provide, and we saw that staff used these processes when patients' conditions required this.
- We found suitable medical cover at all times from a resident medical officer and consultants and noted arrangements for consultants to provide cover for absent colleagues.
- There were sufficient numbers of nursing and support staff to meet patients' needs.
- We saw there were efficient and effective methods for the handover of care between clinical staff.
- There was a designated lead for safeguarding children and vulnerable adults. Staff were trained appropriately to recognise and report suspected abuse in children and vulnerable adults.

However:

- None of the ten surgical case notes reviewed for consultant entries contained entries to demonstrate daily visits as per the requirements of practising privileges. Two sets of notes had documentation about the consultant's visit from the nurse in charge of the patient's care.
- Two patients receiving oxygen did not have oxygen prescribed on the medication record. This was raised at the time of inspection and immediately actioned.
- Patient specific directives (PSD) for bowel preparation did not always evidence that the patient had been assessed by the prescriber before it was supplied. We informed management who initiated a review of the dispensing process at the time of inspection.

Are services effective?

Good

Are services effective?

We rated effective as good because:

Summary of this inspection

- We saw hospital policies and procedures had been developed in line with national guidance and staff were aware of how to access them.
- 100% of staff had completed an appraisal. The hospital encouraged staff to participate in training and development to enable them to develop their clinical skills and knowledge.
- We saw evidence of effective multidisciplinary team working between allied health professionals, nursing staff, medical staff and administration staff.
- Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- A variety of hot and cold food was available. The hospital had access to food for patients out of hours and there was a good choice for patients including vegetarian, gluten-free, lighter options and multi-cultural food choices.
- The hospital had a dedicated lead for professional development who managed the processes for ensuring all staff had received the training and competency assessments applicable to their roles. Staff on the ward and in theatres had link roles and provided training sessions and resources to support their link role.

However:

- We saw that checks were made to ensure patients had adhered to fasting times before surgery went ahead, but at the time of inspection, the hospital did not undertake audits to identify actual fasting times and whether these met the expected standard.

Are services caring?

Good

Are services caring?

We rated caring as good because:

- The hospital achieved a score of 100% for NHS funded patients who stated they were very likely or likely to recommend the hospital to family and friends in May 2016.
- During the inspection, we observed warm, open and positive interactions between staff and patients.
- All patients we spoke with were happy with their care and we received universally positive written feedback from patients during the inspection.
- Patient-led assessments of the care environment (PLACE) for privacy, dignity, and wellbeing within the hospital scored 93%; higher than the England average of 87%.

Summary of this inspection

- Patients felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further information.
- Staff provided support to patients in a timely, professional way. We observed staff giving reassurance to patients who were anxious when awaiting surgery and responding compassionately to patients with pain and discomfort.

Are services responsive?

Good

Are services responsive?

We rated responsive as good because:

- There were effective arrangements in place for planning and booking of surgical activity including waiting list initiatives through contractual agreements with the clinical commissioning group.
- Patients had a choice for booking the dates and times of outpatient and diagnostic imaging appointments. Patients we spoke with confirmed appointments were offered that suited their needs. None of the patients we spoke with raised any concerns about being able to access appointments in a timely manner or delays in clinic.
- There was an effective system in place to provide trained chaperones and staff were familiar with ensuring chaperones were made available for patients.
- Between April 2015 and March 2016, the hospital received 12 complaints. The number of complaints was lower than the average of other independent acute hospitals for which CQC hold data. Complaints were dealt with in a timely manner and no complaints were referred to the Ombudsman or the Independent Sector Complaints Adjudication Service.
- The hospital held a daily meeting of department leads to discuss staffing levels and clinical needs. Ward nursing staff and the nurse manager reviewed planned patient discharges in handovers throughout the shift to assess on-going availability of beds.
- The rate of unplanned transfers of care from this hospital to a nearby NHS trust, unplanned readmissions and unplanned returns to theatre was similar to or better when compared to independent hospital performance data held by CQC.

Are services well-led?

Good

Are services well-led?

We rated well-led as good because:

Summary of this inspection

- We saw strong leadership of services and staff spoke positively about the culture within the organisation. During our inspection, it was clear that the quality of patient care and treatment was a high priority. Staff were proud of the job they did and without exception, the staff we spoke with enjoyed working at the hospital. Staff were familiar with the corporate vision and values and opportunities to develop leadership skills were supported.
- There was a clear governance structure and a comprehensive reporting framework in place that provided timely information to the hospital board, medical advisory committee and to the corporate team. Consultants we spoke with felt there was a good working relationship and strong engagement with the hospital leadership team and that consultants were involved with clinical governance issues. There was evidence that the senior management team were responsive to and ensured action was taken to mitigate identified risks. There were effective arrangements in place to ensure the conditions of practising privileges were met.
- All departments had regular staff meetings. We reviewed the minutes of meetings in each department and noted good attendance and discussion of key items such as information governance, the risk register, audit outcomes, complaints, incidents and infection control.
- The hospital held focus groups between staff and patients to enable patients to share their experiences. These provided opportunities for learning and were valued by the staff and patients.
- The senior management team made themselves accessible to hospital staff by being visible in the departments and engaging with staff. Their approach included holding open invitation breakfast and afternoon tea sessions with staff. Staff said they felt able to raise concerns and were confident that they would be dealt with appropriately.

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	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Good

Surgery

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

Are surgery services safe?

Good

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

We rated safe as good.

Incidents

- In the reporting period, April 2015 to June 2016, there were no Never Events and no serious injuries. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In the reporting period, April 2015 to March 2016, there were 181 incidents within surgery services. Of these, 121 caused no harm, 53 low harm, six moderate harm and one reported unexpected death post-discharge. Nursing and medical staff we spoke with were aware of the reporting system and staff could describe their roles in relation to incident reporting and investigation. All staff we spoke with said that they received feedback after submitting an incident report. Learning was cascaded via the governance committees and received at staff team meetings.
- In the same reporting period, there was one unexpected death, which occurred after a post-operative unplanned transfer to NHS care. This was investigated in liaison with the NHS trust who received the patient and a root cause analysis completed. Nursing staff were aware of the lessons learned from this event; however, the Resident Medical Officer (RMO) was less familiar with the outcome. There did not appear to be a clear mechanism to share learning from unplanned transfers and patient safety incidents with the RMO.
- Staff we spoke with were aware of being open and honest with patients. They provided examples of when they had discussed incidents with patients such as reasons for unexpected transfer, wound infections and theatre cancellations. Staff received training on the Duty of Candour and were aware of how this was implemented in the event of an unintended or unexpected incident such as a deep surgical site infection. We saw evidence of the Duty of Candour being implemented including the letter sent to the patient and discussions with the patient.
- Three incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism occurred in the reporting period April 2015 to March 2016. These incidents were investigated by the Matron and the patients were found to have been appropriately risk-assessed and treated.

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

- The matron completed a monthly report summarising patient safety and experience data, a separate safety thermometer dashboard as well as a quality governance report. These were reviewed at the hospital board meeting and the hospital's clinical governance committee and outcomes submitted centrally to

Nuffield Health. Patient safety performance was not displayed in the hospital for patients and visitors to see but outcomes and lessons learned were cascaded to all staff through staff meetings.

- VTE assessments showed 100% compliance in the reporting period April 2015 to March 2016. The compliance rate was much better than expected when compared to the data held for other independent hospitals.

Cleanliness, infection control and hygiene

- Wards and departments were visually clean. Cleanliness checklists were completed by housekeeping staff and on display in every bathroom. Monthly cleaning audits were undertaken by the heads of department; the result for June 2016 for the inpatient unit was 85%. Internal patient satisfaction surveys indicated 96% satisfaction for cleanliness. We reviewed patient led assessment of the care environment (PLACE) results for the hospital and noted 100% for cleanliness, above the national average of 98%.
- There were carpets present in corridors and patient bedrooms; however these were installed prior to the introduction of the Health Building Note 00-09: Infection control in the built environment, 2013. This guidance recommends that carpets should not be used in areas where frequent spillage is anticipated. The hospital had completed a risk assessment for decontamination of carpets and a hospital wide refurbishment plan to replace carpets with washable flooring in place. Facilities were available for the prompt and effective removal of any spillage, carpets were cleaned monthly and cleaning audits were undertaken. Staff said in the event of a spillage, the carpets would be cleaned following the appropriate procedure. The refurbishment programme was starting in the outpatients department in September 2016.
- A wide range of infection prevention and control (IPC) policies and procedures were in place including an adult sepsis screening tool. The matron was the IPC lead for the hospital, supported by an infection prevention coordinator who had IPC specialist training.
- There were link nurses for IPC across all hospital departments. IPC nurses in the Nuffield Health group acted as a resource and support to the hospital. The hospital had a service level agreement with a microbiologist from the local NHS trust to provide expert IPC advice and guidance. The consultant attended the Infection Prevention Expert Advisory Group, which met quarterly.
- The IPC link staff held monthly meetings with the matron at the Infection Prevention Monitoring Group and both groups reported to the Clinical Governance Committee. An example of action taken was a review of pre-assessment processes to improve the quality of information on pre-operative antibiotic therapy and staff education on the possibility and impact of antimicrobial resistance.
- The hospital reported zero cases of hospital acquired Methicillin resistant staphylococcus aureus (MRSA) and hospital acquired clostridium difficile (C. difficile) in the reporting period April 2015 to March 2016.One reported case of Escherichia coli (e-coli) infection was reported in the same reporting period. This was fully investigated and lessons learned around antibiotic prescribing. We noted 98% compliance for screening surgical patients for MRSA during the reporting period September 2015 to September 2016.
- Alcohol gel was available at the entrances to the hospital and inpatient and surgical unit. We observed staff using hand gel between patients and we observed staff being compliant with 'bare below the elbows' policies. Hand hygiene audit data showed 87% compliance in August 2016. We observed compliance with IPC policies for example washing hands and use of personal protective equipment.
- Clinical wash-hand basins were not available in the surgical unit trolley rooms where patients recovered from procedures such as endoscopy and gastroscopy. Wash-hand basins in the en-suite of these rooms did not comply with Health Building Note 00-09: Infection control in the built environment (2009) for clinical hand washing. However, the basins were installed before the introduction of this standard and we observed staff washing their hands appropriately. This was reported to the senior management team who planned to review the availability of clinical hand-wash basins in the area and included this in the action plan drawn up at the end of the inspection.

Good

Surgery

- The hospital carried out surgical site infection surveillance. Data supplied to us by the hospital showed that there were six surgical site infections during the reporting period April 2015 to March 2016. The hospital also participated in national infection surveillance.
- The rate of infections following primary knee replacement from April 2015 to March 2016 was worse than the average of NHS hospitals at 0.74 per 100 operations. We discussed this with the lead for infection prevention who was aware of the issues. We were not aware of specific action being taken.
- The rate of infections during primary hip replacement from April 2015 to March 2016 was below the average of NHS hospitals at 0.4 infections per 100 operations.
- Equipment cleaning assurance labels indicated that re-usable patient equipment was clean and ready for use. Commodes we inspected were clean, labelled and ready for use. Clean equipment was stored in a separate clean utility room. All cleaning products and equipment were stored appropriately.
- The hospital carried out infection prevention and control audits of environment and practices. A recent change in practice in response to audit results included using intermittent catheterisation post-operatively instead of a long-term catheter, to reduce the risk of urinary tract infections.
- The infection prevention and control lead delivered face-to-face training and an e-learning package was available. IPC training compliance rates for the hospital was 93% in July 2016. Compliance was 100% on the ward and 96% in theatres. A practical IPC session was being rolled out to all staff and at the time of inspection had achieved 74% compliance hospital-wide.

Environment and equipment

- In the inpatient area, we saw that staff checked the adult resuscitation equipment daily and paediatric resuscitation equipment was also available and checked daily.
- A hoist was available for use if required on the ward. Theatre staff we spoke with said there were adequate stocks of equipment and we saw evidence of stock rotation to ensure equipment was used prior to expiry date.
- The Association of Anaesthetists of Great Britain and Ireland (2012) recommend a pre-use check of anaesthetic equipment. We reviewed the safety checks of two anaesthetic machines; the records reviewed provided assurance that daily safety checks were undertaken.
- Staff we spoke with and documents reviewed confirmed the endoscopy equipment washer was taken out of service frequently due to non-compliant rinse-water test results. Senior management were working with the manufacturer to improve results. This issue was recorded on the risk register.
- During the inspection, we observed a fire escape route used as a storage area for consumables. We reported this to the senior management team and immediate action was taken to clear the corridor. A fire risk assessment was last conducted in November 2015 and the action plan completed.
- We reviewed five pieces of electrical patient equipment, which had been routinely checked for safety with visible electrical safety testing stickers on the equipment. These indicated when the equipment was next due for service.
- Nuffield Health York Hospital used an off-site corporate processing hub for managing sterile services and supplies. Surgical instruments were available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if required. Recording systems for use of implants were in place.
- The hospital had recently reported issues with the theatre ventilation system failing to keep the temperature within the required parameters. Theatres overheated on two occasions causing surgery to be cancelled. A chiller component was on order and the problem was expected to be resolved. This was recorded as a risk on the risk register.

Medicines

- Pharmacy staff provided a 24-hour on-call service, seven days a week. The resident medical officer was also able to access pharmacy and supply medications out of hours; a standard operating procedure was available for this practice.

- Medicines were stored in a locked room, with access restricted to authorised staff. Patients own medications were stored in locked bedside cabinets. Medicines requiring refrigeration were stored in fridges. These were locked and the temperatures were checked daily; staff were aware of the action to take if the temperature recorded was not within the appropriate range. Emergency medicines were readily available and they were found to be in date. Intravenous infusions were stored in a locked room.
- Controlled drugs are medicines, which are secured in a designated cupboard and their use recorded in a special register. The controlled drugs records we reviewed were accurate; however; on two occasions on the inpatient ward over August 2016, witness signatures were missing. We highlighted this to the ward manager at the time of the inspection and staff were alerted to completing the register fully. The pharmacist conducted a quarterly audit of controlled drug management including documentation and followed up the results with staff.
- Pharmacists visited the ward daily Monday to Friday to check current stock levels, review pre-assessment medications and discharge medications. Pharmacy staff also saw patients at the time of admission to review their prescription charts. Patients we spoke with had all seen a member of the pharmacy team during their admission.
- Patients were allowed to self-medicate if they had been an inpatient for over 24 hours, had been seen by a member of the pharmacy team and were assessed as competent. A standard operating procedure was in place.
- We looked at the prescription and medicine administration records for nine patients on the ward. We saw arrangements were in place for recording the administration of medicines. These records were clear and legible. The records showed patients received their medicines when needed and as prescribed. Records of patients' allergies were recorded on the prescription chart. However, neither of the two patients receiving oxygen were prescribed oxygen. This was raised with the RMO and immediately actioned.
- The pharmacy team carried out audits of antibiotic prescriptions and the outcomes during April 2015 to March 2016 highlighted an issue with overprescribing of antibiotics. In response, an education package was developed and a change in practice to prescribe antibiotics more effectively had taken place.
- During the inspection, we noted that patient specific directives (PSD) for bowel preparation did not always evidence that the patient had been assessed by the prescriber before it was supplied. A PSD is written instruction, signed by a doctor or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. We highlighted this finding at the time of the inspection and the senior management team took immediate action to prevent inappropriate prescribing by setting up further training and requiring completion of relevant competencies.

Records

- The hospital had an on-site medical records department and used an electronic tracking system to locate medical records. All medical records were archived after one year. NHS medical records were accessed from the local NHS hospital if consultants required them. These were stored and returned following the discharge of the patient. The hospital told us that from April to June 2016, no inpatients had been seen without medical records being available. If this did occur, an incident report was submitted.
- There were thirty-six information governance incidents from April 2015 to July 2016. These included misfiling documents, issuing documentation to the wrong patient, incorrect patient details, failure to identify patient details correctly including same name, using the wrong addressograph label and lack of labelling. This was a low proportion of the number of bookings and procedures made during the same period. Management had taken a number of actions in response to these incidents including reporting the occurrences internally and corporately, sending a memo to all staff about the importance of information governance and providing information governance training with consequential role-play to staff
- In the same reporting period, it was noted that documentation errors had occurred on five occasions (0.14% of all booking forms) due to the procedure being

put on the theatre list stating the wrong side for surgery. This was due to errors made at the initial booking of the procedure by various individuals. All incidents were investigated and addressed with the responsible person on an individual basis; none of these incidents led to wrong-side surgery and all were identified by staff or patients prior to surgery.

- We reviewed 25 sets of care records in total whilst on site and records were legible, complete and contemporaneous. Patient records were multidisciplinary and we saw that physiotherapists, the resident medical officer and nursing staff had made entries.
- To meet the requirements of practising privileges, a consultant should make a daily entry in patients' records, at the time of their visit. However, we reviewed 10 sets of care records for consultant entries and none of the records had daily entries from the patient's consultant. Two records had documentation about the consultant's visit from the nurse in charge of the patient's care. We reported this to the Hospital Director who intended to discuss documentation standards with consultants at the next Medical Advisory Committee.

Safeguarding

- Surgical services for children aged 15 and younger were withdrawn in November 2015, but continued for 16 and 17 years olds as part of adult services.
- The Matron was the safeguarding children and adults lead at the hospital. The matron, resident medical officer, hospital director and most clinical heads of department were trained to Level 3 in safeguarding children. Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by refresher training. In July 2016, the compliance rate for Level 2 safeguarding children training was 95% and for safeguarding vulnerable adults Level 1 was 93%, against the hospital's target of 100%.
- The hospital had systems and policies in place for the identification and management of adults and children at risk of abuse. There was a safeguarding children, young people and adults policy and procedure, which included flowcharts for identifying concerns, safeguarding procedures and guidance on female genital mutilation (FGM).
- Staff we spoke with could describe their roles in relation to the need to report and take action when safeguarding issues were identified.

Mandatory training

- The hospital target for mandatory training completion was 100% compliance; levels of compliance for individual training modules as at the beginning of September 2016 ranged from 88 to 100% in theatres and 86 to 100% on the ward. Full compliance was expected to be achieved by the end of the year.
- Consultant staff attended mandatory training at the NHS trust, which was their main employer and this was evidenced through the appraisal process. The resident medical officer received mandatory training through their agency employer. Completion of these modules was a requirement of their role and reviewed through the appraisal process.
- Staff confirmed they were allowed protected time to complete mandatory training including attending annual resuscitation and scenario training. We were told mandatory training was delivered as face-to-face training sessions or via e-learning programmes on the corporate intranet.

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

- There was a corporate admission policy in place and a team of registered nurses assessed patients in pre-assessment clinics prior to surgery. Any concerns or additional information were communicated to the patient's consultant and anaesthetist prior to the patient's admission. Staff we spoke with were knowledgeable about the pre-assessment process and the criteria for admission.
- Anaesthetists and pre-assessment nurses calculated the patient's American Society of Anaesthesiologists (ASA) risk grade as part of their assessment of a pre-operative patient. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels, with Level 1 being the lowest risk. The hospital predominately undertook procedures for patients graded as Level 1 or 2 and a small number at Level 3.

- The hospital used the modified early warning score (MEWS) tool for identifying deteriorating patients and these assessments were noted to be complete in the case notes reviewed. Staff escalated deteriorating patients to the senior nurse and the RMO.
- The MEWS score was recorded with each set of patient observations. The quality of MEWS documentation was audited quarterly and was an area for improvement. The audit prior to inspection found compliance to be 80% and action had been taken to communicate with staff to improve the standard of documentation in team meetings. The 20% discrepancy related to the fact that the MEWS score was recorded for each indicator but not added up. Further training on MEWS was provided by the resuscitation trainer during mandatory training and the subsequent audit found 90% compliance.
- There was a hospital policy in place for the emergency management of cardiopulmonary resuscitation. Regular simulated cardiac arrest scenarios were carried out so staff were able to respond quickly and effectively. An anaesthetist was on site at all times when patients were in the recovery room post-operatively. A resident medical officer (RMO) trained in advanced life support was on duty 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient's clinical condition. In addition, the ward manager, theatre manager, two senior registered nurse in theatres and two senior registered nurses on the ward were trained in advanced life support.
- The hospital used the National Patient Safety Agency five steps for safer surgery safety checklist based on the World Health Organisation (WHO) checklist. The hospital demonstrated 100% compliance with the safety checklist via observational and retrospective documentation audit. During the inspection, we observed three operations and reviewed six sets of surgery care records for compliance with the use of the WHO safer surgery checklist. From this review, the hospital demonstrated effective compliance with the requirements of the safer surgery checklists.
- A supply of blood was available in the hospital for use in an emergency, such as a major haemorrhage which is excessive blood loss and can be life threatening. Special blood products could be ordered from the local NHS provider and arrive on site at short notice. Simulation of the major haemorrhage protocol activation took place and a night nurse told us this procedure had to be implemented during the night recently and had worked well.

Nursing and support staffing

- There were adequate numbers of suitably qualified and skilled staff to meet the patients' needs. The hospital informed us they used the Royal College of Nursing (RCN) guidelines of 1:7 or 8 nurse to patient ratio and theatres used the Association for Perioperative Practice (AFPP) guidelines. Staffing was reviewed on a daily basis for the forthcoming shifts and adjusted according to clinical need and theatre activity. A weekly capacity meeting was held each Thursday morning to review the following week's activity and staffing levels. Skill mix reviews were done when staff left and at each monthly one-to-one with the Matron and Heads of Departments.
- At the time of the inspection, the inpatient department had 13.3 WTE registered nursing posts and 4.1 WTE healthcare assistant posts. The vacancy rate was 11% with vacancies of 1.7 WTE registered nurses and none for healthcare assistants.
- The theatre department had 9.3 WTE registered nursing posts and 11.9 WTE healthcare assistant (HCA) and operating department assistant (ODP) posts. The vacancy rate for theatre nurses was 23% (2.3 WTE). The hospital had no vacancies for ODPs and HCA roles.
- Use of bank and agency and staff turnover for inpatients and theatres was lower than the average of other independent acute hospitals April 2015 to March 2016. If additional staffing (above normal levels) was required, the head of department made a request, which required approval by Matron.
- We reviewed duty rosters for the previous three months for the inpatient ward and these showed the staffing ratio met the expected standard. On 11 occasions, one registered nurse was on duty supported by a healthcare assistant, however this was when patient occupation rates were low and an additional senior nurse was on-call if the situation changed. The hospital had identified a need for additional twilight staff to facilitate late theatre lists and patient discharges; this was in the process of being implemented.

Good

Surgery

- There were formal on-call arrangements for theatre staff to cover out of hours should an unplanned return to theatre be required including arrangements to allow an adequate rest period the following day. The hospital adhered to the recommendations of the 'Association for Perioperative Practice' with regard to numbers of staff on duty during a standard operating list.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that the information shared was clear, with discussion around individual patient's needs, risks and discharge planning.
- Three part-time registered nurses staffed the day case surgical unit. Depending on the number of theatre bookings, the unit could be open from 6.30am until 7.15pm. Two staff were allocated to work in this area during busy periods; however on a weekly basis, staff could be working alone. Due to the layout of the unit, we discussed lone working risks with management and in response; they carried out a risk assessment and identified mitigating actions to protect staff and patients.
- All staff received a structured induction programme and new staff we spoke with felt supported on joining the organisation.

Medical staffing

- All patients were admitted under the care of a named consultant. There were 105 consultants employed at local NHS trusts who provided surgical care for patients at Nuffield Health York Hospital under practising privileges. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have been approved to practise there. Consultants new to the hospital received an induction from the senior management team.
- Staff told us when the RMO and nursing staff needed to seek medical advice or support out of hours, they contacted the patient's consultant in the first instance. Consultants were expected to be no more than 30 minutes away according to the terms of their practising privileges. The hospital carried out a formal risk assessment if a consultant did live outside this travel time. If a consultant was aware that they would be absent, they informed key senior staff at the hospital in writing and confirmed their cover arrangements. We saw an example of this system in practice.
- The hospital had an out-of-hours rota for anaesthetists to provide 24-hour cover for patients post-operatively and there was a service level agreement for emergency transfer arrangements with the local NHS trust. The ear nose and throat surgeons had developed a collaborative to allow them to cover each other's inpatients.
- There was an RMO onsite 24 hours a day, seven days a week and a weekly rotation with a Monday handover. There was provision of an on-site residence for the RMO. We were unable to observe this formal handover.
- Informal handovers between nursing staff and the RMO and between consultants and the RMO occurred during the shift as required. However, we noted that there was no formal mechanism for the RMO to access the governance systems and lessons learned from patient safety incidents.
- The RMO and nursing staff raised no concerns about the support they received from consultants or their availability out of hours. They reported excellent working relationships and good communication about patient care and treatment plans.

Emergency awareness and training

- The hospital had a business continuity plan. This was available to staff on the hospital shared drive. We saw the plan, which outlined the process for managing and coordinating the hospital's response to an emergency. Staff we spoke with were familiar with these plans and had received regular scenario exercises.
- Monthly tests took place on the backup generator and routine fire drills were undertaken.
- An emergency file was available in all areas for staff to use, outlining actions to be taken and contacts during emergencies. The major incident procedures had been followed during recent floods of the city when staff and patients were unable to access the hospital.

Are surgery services effective?

Good

Surgery

Good

We rated effective as good.

Evidence-based care and treatment

- Nuffield Health care pathways were based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons. We saw the service used standardised care pathways for specific procedures for all patients undergoing surgery. Policies referenced national guidance and staff we spoke with were able to access these on the intranet. Nursing staff assessed, monitored and managed care on a day-to-day basis using nationally recognised risk assessment tools; for example, for falls, malnutrition and pressure damage.
- The hospital took part in all the national clinical audits for which they were eligible. These included Patient Reported Outcome Measures (PROMS), National Joint Registry (NJR), Ionising Radiation Protection Regulations IR(ME)R, Commissioning for Quality and Innovation, (CQUINS), and National Confidential Enquiry Perioperative Deaths (NCEPOD). The delivery of day surgery was consistent with the British Association of Day Surgery (BADS). BADS promotes excellence in day surgery and provides information to patients, relatives, carers, healthcare professionals and members of the association.
- The hospital reviewed compliance with NICE guidelines as they were issued. The report on compliance with 49 guidelines from April to June 2016 showed that 34 were not applicable to Nuffield Health York Hospital activity, nine were assessed as compliant, five were awaiting an assessment and one was partially compliant. Progress with compliance was monitored on a monthly basis.
- Local audit outcomes were reported to the Clinical Governance Committee and submitted to the corporate head office to inform benchmarking tools across the group. The ward and theatres completed quality assurance audits on a quarterly basis including VTE assessment, falls, WHO surgical checklist, healthcare records, IPC, catheter management and discharge. The results of the audits were shared by the senior management team through staff team meetings. Results that were available showed good performance and improvement plans in place where needed.
- The hospital recorded all implants in the theatre implant register. Orthopaedic implants were also recorded on the relevant National Joint Registry record. At the time of inspection, the national Breast and Cosmetic Implant Registry had not yet opened but the hospital maintained records of all breast and cosmetic implants.

Pain relief

- Information about prescribed medicines including how to use them and any side effects was discussed with patients prior to surgery and following their operation. This enabled the patient to communicate effectively with staff to obtain the correct medication to relieve symptoms such as pain following their surgery.
- Regular and as required pain relief was prescribed on all the prescription charts we reviewed. Patients we spoke with said they were offered pain relief regularly and in a timely manner.
- Staff used a pain-scoring tool as part of the modified early warning score tool (MEWS) to assess patient's pain levels. We observed staff reviewing patients' pain levels in the recovery area post-surgery and on the ward. We saw that staff offered pain relief and checked that the pain relief administered had been effective.
- As part of the patient satisfaction survey, the hospital asked patients, "did staff do everything to control your pain and discomfort?" The hospital scored 96% in April 2016, which was better than the overall score for all hospitals in the group.

Nutrition and hydration

- We saw patients being offered drinks and food. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes by using the Malnutrition Universal Screening Tool (MUST) nutritional risk assessment.The documentation we reviewed showed good levels of completion.
- Pre-admission information for patients included clear instructions on fasting times for food and drink prior to surgery. For healthy patients who required a general

anaesthetic, this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before. We saw that checks were made to ensure patients had adhered to fasting times before surgery went ahead; however, at the time of the inspection the hospital did not undertake internal fasting audits.

- We reviewed 10 sets of medical notes and nine patients had been fasted for longer than the hospital policy of two hours for fluids. On average, these patients were fasted for six hours for fluids. Fasting times were the subject of a local CQUIN target and following discussion about the findings, the hospital was going to review the method of data collection and audit to provide a clearer picture of compliance with the policy.
- In the notes we reviewed, there were accurate and complete records to show patients' intravenous and oral fluid intake and output was monitored following surgery.
- A variety of hot and cold food was available. The hospital had access to food for patients out of hours and there was a good choice for patients including vegetarian, gluten-free, lighter options and multi-cultural food choices. Patients had access to fresh water where appropriate and all of the patients we spoke with commented positively about the food. The hospital provided three meals a day plus snacks for inpatients.
- The patient satisfaction survey April 2016 showed that patients had scored the overall quality of catering services as 97%, better than the overall Nuffield Health score of 94%. Patient-led assessments of the care environment (PLACE) scoring for the hospital showed ward food assessments as scoring 100%, higher than the England average of 94%.

Patient outcomes

- From April 2015 to March 2016, there were 3,600 visits to theatre and one unplanned return to the operating theatre. In the same period, the hospital reported 10 unplanned transfers of inpatients to an NHS hospital. The proportion of unplanned transfers (per 100 inpatient attendances) to another hospital was not high when compared to the group of independent acute hospitals, which submitted performance data to CQC. Cases of unplanned transfers were reviewed by the clinical governance lead consultant and discussed at clinical governance meetings.
- In the reporting period from April 2015 to March 2016, there were two cases of unplanned readmission within 28 days of discharge, which was not high when compared to a group of independent acute hospitals, which submitted performance data to CQC. The clinical governance committee reviewed both cases.
- The hospital outcomes for the Patient Reported Outcome Measures (PROMS) 2015 for hip replacement and knee replacement primary scores showed the percentage of patients that had improved after each procedure was 'similar' to the England average.
- Most patients who had joint replacement surgery were reviewed in clinic for up to a year following surgery. The hospital had a local protocol to conduct post-operative follow up courtesy calls in relation to all joint replacement patients 30 days after surgery, to ensure their recovery was on track and as expected.
- The hospital provided data to the competition and markets authority (CMA) and had systems in place to upload data to the private healthcare information network (PHIN) from September 2016. This included the number of specific procedures each consultant performed and their outcomes including variances to enable patients to make an informed choice about their surgery.
- The endoscopy unit was working towards accreditation by the Joint Advisory Group for gastrointestinal endoscopy. Staff were aware of work commencing on acquiring accreditation and were developing an action plan. The hospital planned to apply for accreditation in 2018.

Competent staff

- The hospital had an internal appraisal target of 100%. Appraisal records we reviewed showed that this was achieved for nursing staff for the reporting period January to December 2015 and was on target to achieve the same in 2016. All staff we spoke with thought the appraisal process was useful and they had received time for specialist training, education and portfolio development.

Good

Surgery

- New staff had an induction relevant to their role. Staff we spoke with said that they had found induction helpful and it contained relevant information to help them carry out their role. Newly qualified nurses were supported through preceptorship programmes by being allocated a mentor during their preceptorship.
- Agency and bank nurses received an orientation and induction to the ward area following an induction checklist. This included the use of resuscitation equipment and medicines management. We reviewed two checklists and noted them to be completed and that they covered relevant information.
- The RMOs were employed through a national agency, which provided continuing professional education sessions throughout the year. They were mentored by the chair of the Medical Advisory Committee (MAC) when required, but had no formal relationship with the MAC or Clinical Governance Committee. The RMO was supported by nursing and management staff and had daily communication with consultant colleagues.
- There were systems in place to withdraw the practising privileges of consultants in line with policy in circumstances where standards of practice or professional behaviour were in breach of contract. Fitness to practice issues for consultants were assessed and acted upon by the hospital director and the Medical Advisory Committee.
- Systems were in place for revalidation of medical staffing and for the effective management of consultants' practising privileges, which included contributing to their annual appraisal. Appraisals were based on GMC guidance and completed by a medically qualified appraiser. The hospital team worked closely with the medical director at the nearby NHS trust and provided performance and activity information to inform consultant appraisal.
- The hospital had a dedicated lead for professional development who managed the processes for ensuring all staff had received the training and competency assessments applicable to their roles. Staff on the ward and in theatres had specialty link roles such as infection control and provided training sessions and resources to support their link role. Nuffield Health had an on-line academy where staff could access mandatory and further training.
- Healthcare assistants said they had been supported with national vocational qualifications and care certificate programmes. Trained nurses said that they were encouraged to access further training from universities and three staff we spoke with said they were on degree-based training programmes.
- There was a system to ensure qualified doctors and nurses' registration status were renewed on an annual basis. Data provided to us by the hospital showed 100% completion rate of verification of registration for all staff groups working in inpatient departments and theatres. Staff were aware and felt supported through the registered nurse revalidation requirements.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited and staff were observed to have effective working relationships. Physiotherapy worked closely with hospital staff to prepare surgical and orthopaedic patients for discharge and provide follow-up therapy.
- Pathology services were provided for the inpatient unit from the Nuffield Health Leeds Hospital; there was access to a small on-site service and point of care testing on the hospital site.
- We saw evidence of external MDT working; for example with the local NHS trust during transfers between hospitals, investigation of incidents and for providing expertise and support in areas such as microbiology.

Seven-day services

- The hospital had three operating theatres open six days per week. Operating times were from 8am to 8pm weekdays and theatres were available on request Saturdays and Sundays. There was an on-call rota for key staff groups including theatre staff, senior managers, and imaging staff to support the out-of-hours service.
- Access to physiotherapy services were available six days a week, with emergency cover on a Sunday. Clinical staff had access to diagnostic and radiology services 24 hours a day, seven days a week to support clinical decision-making.

- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care. They were accessible out of hours and nominated a colleague to provide cover when not available.
- There was a Resident Medical Officer (RMO) in the hospital 24 hours a day with immediate telephone access to on-call consultants.
- The pharmacy was open Monday to Friday 8.30 to 5pm. Outside these hours, the RMO could dispense drugs for patients to take home. Any items not kept in pharmacy and needed urgently could be ordered from the pharmacy at the local NHS trust 24 hours a day, seven days per week via a service level agreement.

Access to information

- Staff we spoke with said they had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records. Computers were accessible on the wards and in departments and the hospital was moving towards implementing a fully integrated electronic patient record. Staff, including bank and agency staff, had easy access to policies, procedures and guidance through the hospital intranet.
- When patients were discharged, a letter was sent to the patient's GP to inform them of the treatment and care provided. They also received letters informing them of the cosmetic surgery to be performed on their patient prior to the procedure being undertaken. Staff said they had access to General Practitioner (GP) referral letters when patients attended pre-assessment clinic.
- Diagnostic tests results were available using electronic systems. Staff said they had the necessary access to the PACS system should this be required. This meant there would be no delay accessing test results used to assess a patient's suitability for surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was sought from patients prior to the delivery of treatment and compliance with policy was monitored. The local audit programme included a quarterly audit of consent documentation in 20 sets of case notes. The most recent audit found 100% of consent forms met the expected standard. We looked at 10 consent forms during our inspection; consent was appropriately obtained on all the forms we reviewed and these were completed in line with trust policy and department of health guidance.
- Staff were aware of the hospital policy on consent. However, we noted that on one occasion since April 2015, a patient was listed for a right leg procedure and the consultant marked right leg but consented for the left leg. The consent form had been prepared in advance and the error was not noted at the time of gaining the patient's consent; it was noted during the pre-operative safety checks. The form was rewritten and signed for the correct side before surgery. This incident was addressed with the consultant concerned and noted in their hospital records. We were assured that the information would be included in appraisal notes for the NHS employer. This and other incidents were discussed at the Medical Advisory Committee as part of the discussion about patient safety incidents. It was also included in Matron's governance report which was shared with the clinical commissioning group.
- The hospital assessed patients prior to cosmetic surgery. This included identifying psychologically vulnerable patients and ensuring they were referred for appropriate psychological assessment prior to the procedure being performed. The hospital did not audit compliance with the Royal College of Surgeon's recommendation of a two-week cooling off period prior to cosmetic surgery being performed, but from the records we reviewed, all patients had received longer than the two-week period.
- Where patients lacked capacity to make their own decisions, staff told us that they sought consent from the appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Training records for the hospital showed 97% of staff had undertaken mental capacity training against a hospital target of 100%. Deprivation of liberty safeguards training was completed by 97% of staff.

Good

Surgery

- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were available. No DNACPR forms were in place at the time of our inspection.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- The hospital collected data for the friends and family test and had a response rate of 41% for NHS funded patients. The hospital achieved a score of 100% for NHS funded patients who stated they were very likely or likely to recommend the hospital to family and friends in May 2016.
- All patients we spoke with were happy with the care they received and we received universally positive written feedback from patients during the inspection. We spoke with 14 patients and one relative. Comments included: "The whole experience has been faultless" and "friendly, courteous and very, very efficient".
- During the inspection, we observed warm, open and positive interactions between staff and patients. Theatre escorts and nurses were all observed to provide care and reassurance to patients during their journey to and from theatre.
- We saw that staff communicated in a way that was easy to understand and that they modified their tone, language and pace of conversation to suit the patient. We saw that one patient who repeatedly asked very similar questions following a long anaesthetic was treated with sensitivity, support and respect.
- All patients had drinks and call buzzers located within easy reach. Patients told us that staff did not take long to answer call bells. During the inspection, we saw call bells being answered promptly.
- We observed all staff maintaining patients' privacy and dignity. For example, by knocking on doors and waiting for a response before entering, closing doors when carrying out personal care and covering patients to maintain dignity in the anaesthetic room, operating theatre, recovery areas and during transfers between the ward and theatre areas. Patient-led assessments of the care environment (PLACE) for privacy, dignity, and wellbeing within the hospital scored 93%; higher than the England average of 87%.
- Patients were able to have access to their own multi-faith chaplaincy during their inpatient stay.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been fully involved in their care decisions. One patient told us they received "excellent care from start to finish. Every member of staff I have seen during my stay was caring and explained everything in detail". Another patient was extremely positive about his experience preoperatively. He felt he had been "well informed, well prepared and that the communication had been excellent".
- Patients said they were aware of whom to approach if they had issues regarding their care; they felt able to ask questions and that staff were happy to answer any questions. We saw patients being involved in discharge planning and the management of their condition and medications after discharge.
- We saw that ward managers and nursing staff were visible on the inpatient wards and patients were able to speak with them. We observed that medical staff took the time to explain to the patient and relatives the next stages in the plan of care. We observed patients in theatres and the anaesthetic room being given information in a way that would alleviate their anxiety or concern.
- Procedures were in place to ensure that self-funded patients were advised about all possible costs in a clear and understandable format before treatment was delivered. We saw that discussions about costs were handled sensitively.

Emotional support

- Staff provided support to patients in a timely, professional way. We observed staff giving reassurance to patients who were anxious when awaiting surgery and providing support to patients with pain and discomfort. One patient told us that staff were "very

quick to respond to worries" and we observed a nurse completing documentation methodically while making time to help put the patient at ease and laugh and joke with him.

- The hospital outsourced a breast care nursing service from the local NHS trust to support women who were undergoing treatment as an outpatient or having surgery. Specialist support was provided to patients before and after surgery.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- There were effective arrangements in place for planning and booking of surgical activity including waiting list initiatives through contractual agreements with the clinical commissioning group.
- Staff held a daily meeting to discuss staffing levels and clinical needs. Ward nursing staff and the nurse manager reviewed patient discharges in handovers and throughout the shift to assess on-going availability of beds.
- The hospital maintained collaborative relationships with the local NHS clinical commissioning group and NHS provider. This was to ensure patients' needs continued to be met in the local area at times of increased activity for NHS services and to provide assurance on the quality of service provided.
- The hospital was planning to gain Joint Advisory Group accreditation for their endoscopy services to strengthen assurance on the quality of service provided.

Access and flow

- There were 1,018 inpatient admissions, 2,582 day case admissions and 3,600 visits to theatre in the reporting period April 2015 to March 2016. Of these admissions, 33% were NHS funded and 67% were other funded. Orthopaedic, ophthalmology and dermatology procedures accounted for the largest number of surgical procedures performed in the same reporting period.
- The hospital had a pre-assessment service and assessed patients prior to surgery using the American Society of Anaesthesiologists (ASA) physical status scoring system. Patients admitted to the hospital were low risk. Any issues concerning discharge planning or other patient needs were discussed and documented at the pre-assessment stage.
- The provider met the indicator of 92% of incomplete patients beginning treatment within 18 weeks of referral for each month in the reporting period (Apr 15 to Mar 16), except for May 15, Jul 15 and Aug 15.
- In the last 12 months, the hospital cancelled 28 procedures. All cancelled patients received another appointment within the next 28 days, which was expected.
- In the reporting period from April 2015 to March 2016, there were 10 unplanned transfers, two unplanned readmissions within 28 days of discharge and one unplanned return to theatre. The assessed rates of unplanned transfers, unplanned readmissions and unplanned returns to theatre (per 100 inpatient attendances) were not high when compared to the group of independent acute hospitals that submitted performance data to CQC.
- For unplanned returns to theatre, the hospital operated a 24-hour on-call service with a 30-minute response time. In the event of an unplanned transfer to an NHS hospital, the consultant organised admission with the local NHS trust under the service level agreement to receive emergency patients.

Meeting people's individual needs

- Staff risk assessed patients for sensory, psychological and physical impairments during pre-assessment and on admission to ensure appropriate support mechanisms were in place. For example, hearing and sight impairment, learning disabilities, mental health needs and living with dementia. There were links between specialist (NHS) nurses and ward staff to ensure continuity of care and support for patients. The inpatient unit and theatre suite were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available.
- A staff member was assigned as dementia "champion" on the inpatient ward to provide additional support and

training for staff. Patient- led assessments of the care environment (PLACE) scoring for the hospital showed dementia assessment as scoring 85% which was better than the England average of 81%. A designated room was available for people living with dementia or learning disabilities; although this room was not decorated in additional dementia friendly ways.

- Staff were aware of how to access translation services for people whose first language was not English. Staff said that these were booked for the ward in advance, following pre-assessment.
- Patients we spoke with said that they accessed the pre-operative assessment clinic at a time to suit them including Saturday appointments. In the pre-operative assessment clinic, patients requiring therapy support after discharge were referred to the physiotherapy team pre-operatively. Staff did not have access to occupational therapy services so referred patients to local charities to provide help and advice on adaptations.
- Information leaflets were available in corridors and the patient lounge. These included information on submitting a complaint, antibiotic awareness and financial advice. Discharged patients were provided with information about their after-care and the ward contact number in case they had any concerns post-operatively.
- All post-operative patients received a courtesy call from the hospital post-discharge within 30 days to ensure their recovery was progressing as expected.

Learning from complaints and concerns

- The hospital had a complaints policy in place. The hospital director took overall responsibility for the management of complaints, and read and signed all response letters. Where the complaint involved any aspect of clinical care, the hospital matron led the investigation. Hospital staff told us they tried to resolve complaints and concerns as soon as they were raised.
- Formal complaints followed a three-stage process. Stage 1 involved acknowledging the complaint, explaining the process, an investigation and response by the hospital within 20 days. If the complaint was not resolved, it would be escalated to Stage 2. This stage involved a corporate investigation. Stage 3 involved an independent review by the Independent Sector Complaints Adjudication Service (ISCAS) for fee-paying patients, or the Parliamentary and Health Service Ombudsman for NHS patients.
- An acknowledgment letter was sent within two working days of a complaint being received. Where a response to a complaint was not possible within 20 days, a letter was sent to the complainant. Timescales were met and audited in the Quality Governance monthly report. Response letters to complainants included an apology when things had not gone as planned. This was in accordance with the expectations of the service under duty of candour requirements.
- There were twelve complaints received within the hospital from April 2015 to March 2016. No complaints were received about the service by the CQC in the same reporting period. No complaints were referred to the Ombudsman or ISCAS. The assessed rate of complaints (per 100 inpatient and day case attendances) was lower than the average of other independent acute hospitals for which we hold this type of data.
- Staff could describe their role in relation to complaints management and talked to us about changes in practice that had occurred because of a complaint. For example, access to food for relatives and improved Wi-Fi access. Senior staff were aware of the number of complaints and the themes received for their area.
- Staff complaints and the associated learning were a standing agenda item for the monthly clinical governance meetings and cascaded through heads of departments and team meetings. Complaints were included in the monthly matron report, which was discussed at the Medical Advisory Committee meeting. This ensured that consultants were aware of patient experience concerns and the lessons learned.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- There was strong local leadership of the service from the hospital director supported by the matron and heads of departments. Senior staff provided visible leadership and support to staff on a daily basis. The staff we spoke with said that they had good access to senior support whilst on duty and they felt valued as a colleague and employee. We were provided with positive examples of the support offered to staff during periods of sickness. Staff said they could report any concerns they had about the service or practice and it would be listened to and addressed.
- Staff were very proud of the job they did and without exception, the staff we spoke with enjoyed working at the hospital. We found morale to be universally positive. Staff demonstrated a strong belief in delivering high quality service in their individual role and as a team, felt supported by management and were committed to striving for the best patient experience.
- Managers accessed courses run by the Nuffield Academy including coaching, leadership skills and difficult conversations. The recently appointed ward manager had accessed these. Leadership was encouraged through support to gain degree level education and staff told us about programmes that they were attending.
- Consultants felt there was a good working relationship and engagement with the hospital leadership team and staff and that consultants were involved with clinical governance issues. Consultants we spoke with regarded the executive director and director of nursing as effective and approachable.

Vision and strategy for this core service

- The Nuffield Health group-wide corporate vision, 'for the love of life' was supported by four values: 'enterprising, passionate, independent and caring'. Staff we spoke with were familiar with the corporate vision and we saw a display board where staff had signed up to the hospital's values. During our inspection, it was clear that quality of patient care and treatment was a high priority to all staff.
- There was a local business plan in place for sustaining and expanding the services provided at Nuffield Health York Hospital incorporating governance and patient safety priorities. This included a plan to gain JAG accreditation for endoscopy services and expand the available specialties.
- The corporate quality strategy outlined corporate objectives related to increasing access to professional education, standardising surgical pathways and moving towards a fully integrated electronic record system.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place. The Clinical Quality and Safety Group and the Infection Prevention Monitoring Group met monthly. This ensured that patient safety and infection control issues were reviewed on a timely basis. There were quarterly meetings by groups covering infection prevention, medical devices management, medicines management, training and development, resuscitation, point of care testing and blood transfusion. All groups reported to the Clinical Governance Committee chaired by a consultant anaesthetist as designated medical advisory lead. In the absence of the chair, the meeting was chaired by the matron.
- The Clinical Governance Committee reported to the Integrated Governance Committee, which reviewed all areas of clinical and non-clinical risk and performance and reported to the Hospital Board. The Integrated Governance Committee was attended by all heads of departments and areas discussed included clinical effectiveness, clinical audit, the risk register, health and safety, finance, human resources, information governance, practising privileges, marketing and third party contracts. This committee was chaired by the hospital director. The matron produced a detailed monthly governance report, which was submitted to each meeting.
- We saw the trend in information governance incidents identified as a key area of concern when incidents were discussed at the clinical governance groups during 2016. Concerns about the trend had been escalated to the Integrated Governance Committee and Hospital Board and it was identified as a risk area being monitored during our discussion with the Operational Governance Manager, Matron and the Hospital Director. The Information Governance Forum in June 2016

recommended that information governance issues should be covered at every team meeting and this was evidenced in the relevant minutes. The Hospital Director sent out a memo to all staff about the importance of information governance and a legal firm provided information governance training with consequential role-play to staff.

- The Medical Advisory Committee was held quarterly and chaired by a lead consultant. It was attended by a lead consultant from each speciality with practising privileges, the hospital director, director of nursing, pharmacy manager, sales and services manager and finance manager. Minutes demonstrated standing agenda items covering clinical governance, practising privileges, finance and clinical specialty issues and these were circulated to all consultants. The conditions of practising privileges were monitored closely for compliance and records maintained of appraisal, indemnity insurance and registration. Eight consultants had their practising privileges removed in the reporting period April 2015 to March 2016. This was due to the consultants retiring or not using the services of Nuffield Health York Hospital for over 12 months.
- The hospital participated in a corporate peer review exercise in March 2016. The purpose of the service quality review was to identify any areas for improvements and to share best practice. Key findings from the review were shared within Nuffield Health to develop best practice across their hospitals.
- We reviewed two sets of hospital board meeting minutes and noted discussion about quality and clinical governance, the risk register, strategic objectives and improvement plans. We also reviewed minutes for the governance committees, infection control groups and department team meetings. We noted good attendance at the ward and theatre team meetings and discussion of key items such as the risk register, audit outcomes, complaints, patient experience, incidents, documentation and infection control. The hospital risk register had two risks relevant to surgery services both of which demonstrated a recent review date and an appropriate action plan.

Public and staff engagement

- The staff survey provided hospital-wide feedback and was not specific to individual departments except theatres; 91% of hospital staff would recommend Nuffield Health York Hospital services to friends and family. Staff were positive about being encouraged to focus on customer needs, but less so about achieving work-life balance due to shift changes and the demands of the theatre schedule. Actions included management focussing on specific issues that were contributing to late finishes, staff structure, theatre utilisation and consultant engagement.
- Customer Focus groups were held by the hospital to enable patients to share their experiences. We viewed the minutes of the May 2016 Customer Focus group. Six patients and 10 staff attended. The patients expressed their views and opinions of their healthcare experience. Staff described the importance of these meetings and the subsequent improvements made to patients' experience.
- Management responded to feedback from patients and actions included making snacks available, improving the quality of operation gowns, reviewing the facilities for patients living with dementia and introducing a 'You said, We did' board.
- Afternoon teas and breakfast with the senior management team had been held to improve access to the senior management team by staff working in the hospital.

Innovation, improvement and sustainability

- The hospital had prepared systems to collect data to submit to the private healthcare information network (PHIN).PHIN will start publishing information on hospital and consultant performance from April 2017. The data includes mortality rates, infection rates, hospital readmissions and transfers as well as patient satisfaction survey results.
- The hospital supported the enhanced recovery programme including pre-assessment of health, fluid management and early mobilisation. Physiotherapy was available several times a day to contribute towards enhanced recovery

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- There were no never events reported in the service between April 2015 and March 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Serious incidents are incidents that require reporting and further investigation. Nuffield Health York Hospital reported no serious incidents between April 2015 and March 2016.
- Between April 2015 and March 2016 there were 35 clinical incidents reported within outpatients and diagnostic imaging services. This was similar to the average of other independent acute hospitals. Within the same reporting period, there were 37 non-clinical incidents reported within outpatients and diagnostic imaging services. This was higher than the average of other independent acute hospitals, which was noted by management and being monitored.
- The hospital provided us with a breakdown on the number and types of incidents reported in the service between April 2015 and July 2016. Within outpatients there were 12 incidents graded as moderate harm. Within diagnostic imaging, one incident was graded as moderate harm. There were no severe harm incidents.
- The hospital reported no incidents to the CQC in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Staff in the diagnostic imaging department understood their responsibilities for reporting IR(ME)R incidents.
- A root cause analysis (RCA) is a structured method used to analysis incidents. We reviewed one RCA relating to a patient who developed a bacterial infection after undergoing a biopsy. The investigation identified the root cause; included lessons learnt and recommendations. We saw evidence of the recommendations being implemented and all patients now receive a letter post-procedure outlining the details of their procedure. This provided information that could be shown to medical staff should a patient attend urgent care soon after surgery.
- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the hospitals electronic reporting system. The staff we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents.
- Any lessons learnt from incidents were shared via clinical governance meetings and team meetings. We saw evidence of this in individual department meeting minutes. Staff said they would get copies of meeting minutes via emails.
- Staff did not always report incidents that resulted in no harm. For example, staff in physiotherapy described

patients on occasion being booked for appointments at the wrong time and with the wrong therapist. Staff said this would not be reported as an incident despite resulting in a delay in treatment for the patient.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of any unintended or unexpected incident and provide reasonable support to that person. Staff were aware of the duty of candour principles and spoke about being open and honest with patients and their relatives. All staff we spoke to said that they would speak to patients and their families if an incident had occurred.
- Where information governance incidents had resulted in a letter or appointment being mailed to the wrong person, a letter of apology and description of the action taken was sent out. This was in accordance with the expectations of the service under duty of candour requirements.

Cleanliness, infection control and hygiene

- Between April 2015 and May 2016 there were no incidents of Methicillin-Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. difficile) and Methicillin Sensitive Staphylococcus Aureus (MSSA) within outpatient and diagnostic services.
- Between April 2015 and May 2016, there was one incident of E-Coli. The service had completed a RCA following the incident. The RCA identified the root cause, included lessons learnt and recommendations and had a timed action plan, which was being implemented.
- The departments we visited were visibly clean and cleaning schedules were displayed within the physiotherapy department. Within outpatients, we saw cleaning checklists had been completed and were stored in a separate file. The hospital completed monthly cleaning audits. Different elements in clinical areas were inspected against agreed cleaning standards. In June 2016, the average cleanliness score for the outpatient department was 84%, the physiotherapy department scored 95%, the MRI unit scored 99% and the radiology department scored 95%. If the standard was not met, an action plan was implemented which identified the person responsible and a review date.
- All of the consulting rooms were visibly clean and green cleaning assurance stickers were used to indicate when a piece of equipment had been cleaned. We saw disposable curtains were used in the consulting rooms. In one room, the curtains were dated as changed in May 2016.
- We observed staff complying with bare below the elbows policy, correct hand washing technique and use of hand gels in most of the areas we visited. Hand hygiene audit data we reviewed showed 87% compliance in August 2016. We saw personal protective equipment (PPE) such as gloves and aprons were available in clinical areas. In the diagnostic imaging department, PPE equipment including lead coats were checked for cleanliness and found to be in good condition.
- Antibacterial gel dispensers were available in the main outpatient department and in clinical areas. However, we saw limited signage encouraging visitors and staff to sanitize their hands.
- All the departments we visited had carpeted floors. We also saw carpets in consulting rooms where rhinoscopes and endoscopes were used. However, these carpets were installed prior to the introduction of the Health Building Note 00-09: Infection control in the built environment, 2013. This guidance recommends that carpets should not be used in areas where frequent spillage is anticipated. However, a risk assessment for decontamination of carpets and a hospital wide refurbishment plan to replace carpets with washable flooring were in place.
- Facilities were available for the prompt and effective removal of any spillage, carpets were cleaned monthly and cleaning audits were undertaken. Staff said in the event of a spillage, the carpets would be cleaned following the appropriate procedure. The refurbishment programme was starting in outpatients in September 2016.

Good

Outpatients and diagnostic imaging

- All of the equipment used in the outpatient department (with the exception of scopes) was single patient use, therefore, reducing the likelihood of the transmission of hospital acquired infections.
- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments we visited.
- In the outpatient department, we found some used scopes in the dirty utility room that were waiting to be cleaned. This room was unlocked and could be accessed by patients. We also found an opened tube of petroleum gel. We spoke with the infection prevention control nurse who confirmed this was not appropriate for multiple patient use. The tube was removed from the clinical area and the pharmacist confirmed that the hospital had small single-use sachets that staff should use.
- If a patient had a communicable disease, outpatient staff said they would seek advice from the matron or the infection prevention control lead nurse. Within diagnostic imaging, staff said they would decontaminate the equipment before further use if a patient with an infection or communicable disease was examined.

Environment and equipment

- Patient led assessments of the care environment (PLACE) assessed how the environment supported patient's privacy and dignity, food, cleanliness and general building maintenance. In 2016, the hospital scored the same or higher than the England average for cleanliness, condition, appearance and maintenance, dementia, food, organisational food, privacy, dignity and wellbeing and ward food. The PLACE audits were not specific to outpatient and diagnostic services.
- Adult resuscitation equipment was available in the outpatient department and MRI suite. We checked the resuscitation trolleys in all the clinical areas and found daily and weekly checks had been completed in line with best practice and all the trolleys were sealed with tamper-proof tags. All consulting rooms had emergency call buttons that staff could press in an emergency situation.
- Following the withdrawal of inpatient paediatric services, the paediatric resuscitation trolley in the outpatient department had been downgraded and the intubation drawer had been removed. We checked the trolley and found daily and weekly checks had been completed.
- We checked a range of equipment and found that all the pieces of equipment had visible evidence of electrical testing indicating safety checks and when it was next due for servicing. We found a urine testing machine that had a sticker stating 'do not use after 2014'. We raised this with the outpatient department manager who addressed this immediately. On the second day of our inspection, we saw that this had been tested and was now due to be tested again in 2017.
- We found eight needles in a consultant room that expired in May 2015. We raised this with the outpatient department manager and they were removed immediately. We were provided with assurance that all stock would be checked to ensure they were all in date.
- An audit of radiology equipment in October 2015 found the radiology equipment was maintained to a high standard and all equipment was subject to a comprehensive preventative maintenance programme of regular servicing. The audit found the in-house quality assurance programme was well established; this included all essential tests in accordance with IPEM Report 91(Institute of Physics and Engineering in Medicine) guidance.
- Annual quality assurance checks were completed for all radiological equipment including mammography x-ray, panoramic dental x-ray, fluoroscopy unit, mobile x-ray unit, x-ray tube and generator. We reviewed the reports from 2015 and found that all the equipment in the unit was satisfactory with the exception of the mammography machine. The report recommended that the unit should be included in a programme for progressive replacement of equipment to ensure it was replaced before its performance fell below the acceptable level. The recommendation was actioned.
- Individual companies were contracted to maintain their own equipment. Annual dates were agreed for maintenance checks to allow the service to plan for the equipment to be out of commission during maintenance. The companies also provided a weekend service.

Good

Outpatients and diagnostic imaging

- Appropriate protective equipment was available for all staff and patients in radiology. Staff wore personal radiation dosimeters (dose meters) and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionizing radiation.
- The specialist scanner for measuring bone density underwent a daily quality assurance programme and staff would not proceed with the imaging unless quality assurance was complete.
- Appropriate environmental measures and signage was in place to identify areas where radiological exposure was taking place in line with IR(ME)R regulations. This ensured that staff and visitors did not accidentally enter a controlled zone.
- We saw that staff in the diagnostic imaging department did not lock the doors when x-raying a patient. There was an illuminated panel on the outside of the room that indicated the room was in use and not to enter. There was a risk that a visitor or member of staff could walk into the room when radiation exposure was possible. The department had not completed a risk assessment for unlocked doors. We raised this with the head of department who said the doors were not locked to ensure quick access in an emergency. A risk assessment relating to the locking of the doors was completed during the inspection.
- The waiting area in the outpatient department was large and spacious with plenty of room for seating and wheelchairs. There were no children's toys in the waiting area; however, staff said they had crayons and colouring pads available from reception.

Medicines

- We checked the storage of medications in the departments we visited. We found that medications were stored securely in appropriately locked rooms and fridges. No controlled drugs were stored in the department.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. We saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range. Staff could describe the process for reporting if the fridge temperature went out of range. The hospital was investing in a new system that would allow 24 hour temperature monitoring.
- In April 2016, the hospital completed a self-assessment of the security and governance arrangements of all medicines within the hospital. The outpatient department and diagnostic imaging were included in the assessment. The assessment found that the hospital had appropriate policies and arrangements in place for the management and security of medicines.
- Consultants in the outpatient department provided private prescriptions for patients. We found that prescription charts were kept in a locked cupboard and a logbook was completed and up to date to show the dispensing clinician and provide an audit trail in line with Department of Health guidance on the security of prescription forms.
- Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography. These materials were safely stored in the diagnostic imaging department and could only be prescribed by the Resident Medical Officer (RMO) or radiologist.

Records

- We reviewed nine sets of records across the outpatient and physiotherapy departments. All were legible and contained all the relevant information such as patient history, allergies and information relating to the procedure was clearly documented. Consent forms were also completed correctly for any patient undergoing a procedure.
- Paper records were used in the outpatient department. Physiotherapy and radiology used a mixture of electronic and paper records.
- We saw that records were appropriately stored within the departments we visited. The hospital had a fully integrated medical record system that allowed all records across all specialities to be stored on site for two years. Within the outpatient department, patient records were stored in a lockable, fire resistant room with access restricted to certain members of staff. Older records were archived off-site.

Good

Outpatients and diagnostic imaging

- Staff said all records could be requested and available for the next day. Over the past three months, the hospital reported that 99% of patients were seen in outpatients with all relevant medical records being available.
- The hospital said that the only time records were not available was if a patient was a late booking. If a patient's records were unavailable, the information was requested from the archive store, scanned to a secure portal and then downloaded from a secure site. All the information was password protected.
- Within outpatients, the booking team had a robust system in place for ensuring all records were available for consultant clinics. Staff took patient records to individual consultation rooms prior to clinics and locked them securely. Staff then collected the records at the end of the clinic.
- Records were not taken off-site. All staff were aware that in accordance with the group health records standards policy and practising privileges policy, staff were not to take any patient records off-site. All medical records were tracked from the medical record department using tracer cards. This provided an audit of the date the record was taken out of the department, who requested it and for what purpose.
- Information governance training was included in the hospitals mandatory training programme. Training records showed 92% of staff within the outpatient department and 85% of staff within radiology had completed the training.
- There was a system in place to request diagnostic images taken at a local NHS provider. These images could be shared using a secure portal and made available for patients attending outpatient appointments.
- Monthly patient identification and IR(ME)R referral form audits were completed to ensure compliance with IR(ME)R regulation. The audit randomly selected 10 request cards. Results from July found 86% compliance. On 70% of request cards, there was no evidence of discussion about previous images and on 70%, the justification box was not completed or signed. The audit found one referral that had no identity checks completed. We were not aware of any specific action being taken.
- We reviewed eight request cards for diagnostic imaging. We found that a number of acronyms and abbreviations were used. Staff said this had been escalated to the hospital director.
- The hospital used the National Patient Safety Agency five steps for safer surgery safety checklist based on the World Health Organisation (WHO) checklist. The radiology service used a modified WHO checklist for procedures such as breast lump biopsies, guided injections into joints and trans-rectal ultrasound prostate biopsy. We reviewed six sets of records for these types of procedures and saw all sets had a completed safety checklist.
- We saw the standard operating procedure for faxing was displayed next to the fax machine in the outpatient department. This had expired in May 2015. We brought this to the attention of the administrative lead.

Safeguarding

- Nuffield Health safeguarding policy provided a framework for all staff when identifying, responding to and reporting any aspects of safeguarding. The hospital's matron took overall responsibility for adult and children safeguarding. Staff we spoke to were clear about how to recognise a safeguarding concern and knew how to escalate safeguarding concerns. All staff knew how to make a safeguarding referral or who to contact if they need further advice.
- One safeguarding concern was reported to the CQC in the reporting period from April 2015 to March 2016. This related to an incident within the outpatient department and we saw staff followed the correct safeguarding procedure.
- The service had withdrawn paediatric inpatient services for children under 15 years old. Children under 15 years old were seen in the outpatient department for consultation only, no invasive procedures were carried out.
- We reviewed training records provided by the hospital and found 92% of staff in the outpatient department had completed safeguarding vulnerable adults level 1 training and safeguarding children level 1 training. Within radiology, 85% of staff had completed safeguarding vulnerable adults level 1 training and safeguarding children level 1 training. The heads of

department had completed safeguarding children level 3 training and the remaining staff were booked on to courses to complete safeguarding children level 2 training.

- The hospital completed relevant checks against the Disclosure and Barring Service (DBS) for employees.
- The hospital had guidance in place for Child Sexual Exploitation (CSE) and a standard operating procedure for Female Genital Mutilation (FGM). We saw notice boards in staff areas in the MRI suite displaying information about safeguarding, FGM and whistleblowing. We saw a FGM flowchart displayed on the wall in ultrasound to support staff when undertaking gynaecological ultrasound scans.

Mandatory training

- Mandatory training topics included areas such as fire safety, health safety and welfare, manual handling, infection prevention and basic life support.
- Staff we spoke with all confirmed they were up to date with their mandatory training. Staff said training was accessible and the majority of training was completed via e-learning. Practical training sessions such as moving and handling were face to face.
- Some staff said it could be challenging completing mandatory training during working hours and they occasionally completed e-learning at home. Staff said they could claim this back as overtime.
- Each head of department confirmed they received a training matrix monthly via an email. They would use this to notify staff that they were out of date with any mandatory training.
- Training data as at the beginning of September 2016 showed that the outpatient and diagnostic imaging departments met the hospital target for all topics with minimal exceptions. It was expected that target levels would be reached for these by the end of the year.
- We saw that all staff in the outpatient and radiology departments had completed intermediate life support (ILS) training.

Assessing and responding to patient risk

- There was a hospital policy in place for the emergency management of cardiopulmonary resuscitation. Regular simulated cardiac arrest scenarios were carried out so staff were able to respond quickly and effectively. A resident medical officer (RMO) trained in advanced life support was on duty 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient's clinical condition.
- It was a requirement of the hospitals practising privileges policy that consultants needed to reside or work within 30 minutes of the hospital to be able to respond in a timely manner. In addition, the hospital had 24 hour, seven day a week cover by anaesthesia.
- The hospital had a service level agreement with a local NHS trust to transfer patients in the event of an emergency or if a deteriorating patient required an increased level of care. All consulting rooms had alarm buttons that could be pressed in an emergency and staff were able to describe the process they would follow if they were concerned that a patient was deteriorating.
- It was identified on the hospitals risk register that the resuscitation alarm in the MRI suite did not sound in the main hospital. The hospital had put in place actions to mitigate the risk including that all staff working in the MRI suite had completed intermediate life support training and could dial '2222' for emergency support if required.
- The MRI suite was in a stand-alone building outside of the main hospital. In March 2016, the hospital undertook an emergency simulation exercise to evacuate a patient from the MRI scanner. We reviewed the cardiac arrest simulation report and saw patients were managed in a timely manner. It took staff 55 seconds to evacuate the patient from the scanner and contact '2222' and then a further two minutes for the team to arrive from the main hospital.
- We saw a policy was in place to ensure the service identified women who may be pregnant. Radiographers checked the status of all women of childbearing age prior to examination. There was also clear signage within the department waiting areas and changing cubicles to ask patients to let staff know if there was a possibility that they were pregnant.

Good

Outpatients and diagnostic imaging

- Within diagnostic imaging, there was a radiation protection supervisor who was responsible for ensuring equipment safety, quality checks and ionising radiation procedures were carried out in accordance with local and national guidance.
- Appropriate environmental measures and signage was in place to identify areas where radiological exposure was taking place in line with IR(ME)R regulations. This ensured that staff and visitors did not accidentally enter a controlled zone.
- We saw appropriate safety checks were completed in radiology. The service implemented a pause and check process and staff completed an 'eight point identification check' to confirm patient details against the original referral. The service had introduced a ninth point check by asking patients to verify if they had undergone an x-ray in the same area in the past six months. This reduced the risk of repeating scans.
- The annual Radiation Protection Adviser (RPA) audit in August 2016 found that the service was fully compliant with the current regulations, standards and guidance relating to the use of ionising radiations in diagnostic imaging.

Nursing staffing

- There were adequate numbers of suitably qualified and skilled staff to meet patients' needs. Staffing was reviewed on a daily basis for the forthcoming shifts and adjusted according to activity. Between April 2015 and March 2016, no agency staff were used in the outpatient department or within diagnostic imagining. This was lower than the average of other independent acute hospitals.
- Data submitted by the hospital showed that as of April 2016, the outpatient department employed eight whole time equivalent staff (WTE). This consisted of 6.9 WTE nursing staff and 1.4 (WTE) health care assistants. There were no staff vacancies within outpatient and diagnostic imaging services.
- At the time of the inspection, the radiology department had four WTE radiographers, four part-time staff and one imaging assistant. The department had three bank staff. There were no vacancies within the department.
- Use of bank and agency staff within diagnostic imaging was lower than the average of other independent acute hospitals between April 2016 and March 2016. In the last three months of the reporting period (April 2015 to March 2016), no agency staff worked in the diagnostic imaging department.
- Staff received a structured induction programme and the staff we spoke with felt supported on joining the hospital.
- The hospital used dedicated bank staff as and when required from the hospitals own pool of bank staff. Bank staff said they completed a local induction and completed competencies. They were invited to department meetings and received annual appraisals.
- The service did not have a dedicated children's nurse as the service had withdrawn invasive paediatric services. If a child attended the with the child's guardian.

Medical staffing

- There were a total of 132 consultants with practising privileges at the hospital. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practice there.
- Staff said there were sufficient consultant staff to cover outpatient clinics and that medical staff were supportive and advice could be sought when needed.
- Medical staff were contacted by telephone, email or via their secretaries to offer advice to staff if they were not present at the hospital and there was an arrangement in place for consultants to provide cover for each other if required.
- Consultants new to the hospital received an induction from the senior management team.
- The hospital outsourced the provision of its resident medical officers (RMO) from a national agency. There was a resident medical officer (RMO) onsite 24 hours a day, seven days a week and a weekly rotation with a Monday handover. There was provision of an on-site residence for the RMO.
- The RMO received a formal induction from hospital staff when first starting at the hospital.

Emergency awareness and training

- The hospital had a major incident handling and business contingency plan. There was an emergency file

detailing the procedure on the ward, reception, and the outpatient department. The diagnostic imaging manager could describe how the department would respond if the servers failed that supported the picture archiving and communication system (PACS). In March 2016, staff in diagnostic imaging undertook a mock patient evacuation of the MRI scanner as part of their medical emergency training.

Are outpatients and diagnostic imaging services effective?

Effective was inspected but not rated.

Evidence-based care and treatment

- Within outpatients and diagnostic imaging, policies and procedures had been developed and referenced to National Institute for Health and Care Excellence(NICE) and national guidance. These were accessible to all staff on the hospital's intranet. In the outpatient department, we saw signature sheets to show that staff had read policies relevant to their job roles.
- The physiotherapy department included reviews of professional journal articles as part of their monthly in service training programme.
- The diagnostic and imaging department did not participate in the Imaging Services Accreditation Scheme (ISAS). However, at a corporate level, the radiology lead was considering having relevant sites apply for accreditation and had identified the hospital as a pilot site.
- In radiology, the service used national guidance for setting diagnostic reference levels in practice to consider the amount of radiation patients were exposed to. We saw evidence of annual audits of patient dose and diagnostic reference levels.
- The radiology department had adopted an '8 point ID check' before carrying out procedures in line with IR(ME)R regulations. The service audited request cards and referral forms to assess compliance with the '8 point ID check'. In July 2016, the audit demonstrated the department was 86% compliant. There was no associated timed action plan with the audit.
- The annual radiation protection advisor audit in August 2016 found that the service was fully compliant with the current regulations, standards and guidance relating to the use of ionising radiations in diagnostic imaging.
- Within the MRI suite, the service used protocols from a local NHS provider that had not been ratified by the hospital. We raised this with the hospital and a representative of the group of radiologists reporting at Nuffield Health York Hospital signed a document acknowledging the agreement to use these protocols.

Pain relief

- Some of the minor procedures that took place in the outpatient department were performed under local anaesthetic. A consultant was present for the procedure and administered the pain relief.
- We observed staff asking a patient to maintain a pain diary following a guided steroid injection and giving information about who to contact if the pain worsened.
- Staff in the physiotherapy department used a score in response to treatment to assess a patient's pain. Staff used the score as a subjective marker to assess the impact of treatments.

Nutrition and hydration

- Food was not readily available however; staff said that if a patient was waiting for a long period of time in the department they would be able to provide a light snack, for example if a patient was diabetic.

Patient outcomes

- The annual Radiation Protection Advisors audit in August 2016 found that the service was fully compliant with the current regulations, standards and guidance relating to the use of ionising radiations in diagnostic imaging.
- The hospital did not audit specific waiting list times for patients to receive an appointment. Staff said that all patients were seen promptly and patient rarely had to wait for an appointment. None of the patients raised concerns about being able to access clinics in a timely manner.

Good

Outpatients and diagnostic imaging

- The outpatient survey asked people if they had experienced a delay in seeing a consultant or nurse beyond their allocated time. We reviewed eight surveys and found all respondents either stated they were seen early or on time.
- Staff in the physiotherapy department were using limited outcome measures, these included range of movement achieved for joints and muscle strength measured using the Oxford scale to assess patient's progress.
- The hospital was due to start submitting outcome data to Private Healthcare Information Network (PHIN) in September 2016.
- The hospital undertook a peer review in March 2016. The purpose of the review was to identify any areas for improvements and to share best practice across hospital sites. The review found no safety related issues related to outpatients or the diagnostic imaging service.

Competent staff

- All new staff completed an induction programme. Staff told us the induction process was comprehensive and enjoyable. As part of the induction process staff were given a list of names of different people within the hospital. Staff had to seek out these people and spend time with them. Staff felt this gave them the opportunity to meet different people and see different departments.
- Data provided by the hospital showed that 100% of outpatient nurses and health care assistants had received an appraisal in the current appraisal year (January 2016 to December 2016).
- Staff described the appraisal process as a valuable experience and felt that their learning needs were addressed; they were also given the opportunity to attend courses to further their development.
- Staff described being supported in undertaking further learning to develop their skills and knowledge. We heard examples of staff being supported by the hospital to complete a diploma degree for health and social care and others being supported in completing a degree in infection prevention and control.
- Monthly one to one meetings were held with the clinical heads of department and the matron to discuss all aspects of the hospital activity. A report was generated from this meeting and personal development plans were embedded to allow monthly updates on specific objectives.
- A Nuffield Health corporate policy was in place to assist the hospital in granting practising privileges. It clearly documented how to apply for, grant and maintain practicing privileges.
- The registered manager and Medical Advisory Committee chair liaised appropriately with the General Medical Council and local NHS trusts about any concerns and restrictions on the practice for individual consultants. Any concerns about a consultant would be shared with their responsible officer within their NHS employment. The hospital contributed information on performance to support the consultants' appraisal process in the NHS.
- Data showed all medical staff had their registration validated in the last 12 months.
- Bank staff said they had an appraisal and had access to further training.
- Nursing staff said they had been supported in receiving information and support around revalidation and there was a lead nurse within the hospital.
- Staff in the physiotherapy department attended monthly training sessions. The head of department kept a list of attendees.
- We saw training records that demonstrated that staff had the theoretical knowledge and practical skills to meet the minimum standard for safe practice in compliance with IR(ME)R. The record was reviewed annually by the radiology manager.
- Imaging equipment used in theatre was operated by radiographers who had completed specific competencies. None of the surgeons acted as operators.
- The radiology manager was the qualified Radiology Protection Supervisor within the hospital. We saw evidence of their most recent update training and evidence of a competence update for their role.
- The imaging department operated a specialist scanner for measuring bone density. Staff had completed a

training programme to operate the machine. The department was planning to train an additional radiographer in operating the scanner as part of the team's succession planning.

Multidisciplinary working

- We observed close working relations between clinical and non-clinical staff within the outpatient department. Staff told us that everyone worked together well as a team.
- Oncologists working in the outpatient department worked closely with NHS providers to provide further treatments including chemotherapy and radiotherapy. A specialist nurse practitioner supported the oncology clinics and offered support to patients and families when receiving difficult news.
- In diagnostic imaging, staff liaised with GPs and NHS providers to offer a specialist scan for measuring bone density to patients.
- We observed nursing staff working in partnership with consultants, healthcare assistants, administration staff, and physiotherapist. Staff were seen to be supportive of each other to provide the best care and experience for the patient.
- Within diagnostic imaging, staff worked closely with the local NHS provider to make use of previous images. If a patient had any previous images, they would be sent via a secure portal and the images could be uploaded.
- There were arrangements in place to transfer patients' care to the local trust in emergencies.
- We saw evidence of communication to GPs informing them of treatments provided, follow up appointments and medications to be taken on discharge.

Seven-day services

- The diagnostic imaging department was open Monday to Friday and had an on-call radiology team who provided cover 24 hours a day, seven days a week.
- The hospital had an on-call physiotherapist on a Saturday and Sunday for postoperative patients.
- A registered medical officer was onsite 24 hours a day, seven days a week to provide any urgent medical care and the hospital had access to an anaesthetist 24 hours a day, seven days a week.
- There was 24 hour access to medicines on-site and if required, from the local NHS trust pharmacy through a service level agreement.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, national guidance and e-learning.
- Staff reported no concerns about accessing relevant patient information. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- The radiology department used a Computerised Radiology Information System (CRIS). The system supported a range of functional requirements such as radiology operational workflow, business analysis and storage of patient data.
- All patients had integrated records that ensured staff had all the relevant patient information.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging. This enabled prompt discussion with patients on the findings and treatment plan.
- There was a system in place to request diagnostic images taken at a local NHS provider. These images could be shared using a secure portal and viewed via the Picture Archiving and Communications System (PACS).
- Clinic information was shared with patients' GPs in letter format. These were produced by the clinician following the appointment and copies sent to GPs and patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff completed Mental Capacity Act training and Deprivation of Liberty Safeguards (DOLS) training as part of the hospitals mandatory training programme. In outpatients there was 100% compliance with training; in radiology 78% of staff had completed the training.
- The hospital used Nuffield Heath corporate policies concerning the use of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Consent to examination or treatment was included in the hospital's mandatory training programme. Training

records provided by the hospital showed staff in the outpatient department were 100% compliant with consent training. In radiology, staff were 78% compliant with consent training.

- Staff reported that they were aware of the consent policy and how to access this on the hospitals intranet. Staff appeared to have a broad understanding of issues in relation to capacity. They explained that any concerns would be escalated to the matron or consultant for further advice or assistance.
- We reviewed seven sets of records and saw that patients undergoing procedures were appropriately consented, and the consent form included a sticker that confirmed any risks had been discussed with the patient.
- Staff in the diagnostic imaging department said that capacity assessments were completed during outpatient consultations or at preoperative assessment. They gave us an example of a patient who was referred back to their GP for further assessments following concerns about their capacity.
- A formalised risk assessment was completed at booking for any women undergoing a mammogram as part of the hospitals '360 health screening'. Consent was gained at booking and the consent form was scanned onto the radiology information system.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good

Compassionate care

- The hospital collected friends and family survey data about NHS patients. Response rates were lower than the England average between October 2015 and March 2016. 98% of patients said they would recommend the outpatient service. This was similar to the England average.
- We reviewed 40 comment cards. There was no negative feedback. Comments included: "I have nothing but praise for all the staff, doctors and facilities"; "the staff are excellent, the environment is 'spot on'. I could not have been treated better"; "wonderful, great service, very quick" and "service was brilliant, friendly and I was treated with respect and politeness".
- The outpatient department completed their own patient satisfaction survey. The results had not yet been collated. We randomly reviewed eight survey forms and found all the feedback to be positive. All patients rated their experience as either excellent or good. The manager was unable to give us any examples of changes to practice as said patient feedback was always positive.
- We spoke with 12 patients in the outpatient and diagnostic imaging waiting area. All patients spoke positively about their experience and told us that staff had respected their privacy and dignity.
- We observed staff interacting with patients and their families in a compassionate and respectful manner. This included staff visiting the waiting area to check on the status of patients waiting for appointments.
- Within the outpatient department and physiotherapy there were individual consulting rooms. The rooms displayed 'free/engaged' signs on the door. This provided privacy and dignity to patients during their consultation.
- Patients were invited to participate in a patient focus forum session. We reviewed minutes of these meetings and found that the views and opinions of patients were listened to.
- Private changing facilities were available for patients in the physiotherapy and diagnostic imaging departments. Rooms contained lockers where patients could safely store belongings.
- Within the outpatient department, the reception desk was in an open environment that did not offer much privacy. Staff said they would use a private room if they needed to have confidential discussions with patients.

Understanding and involvement of patients and those close to them

- Patients felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further

information. Within the diagnostic imaging department, most patients told us they received appropriate information about their care and treatment. The majority of patients told us they understood when test results would be returned to them.

- We reviewed nine sets of records in the outpatient department. All the records had evidence of patients' involvement in discussions about their treatment options, and the risks and benefits of the different treatments. Following their appointments, patients were given a letter detailing the time and date of their next appointment and information about who to contact if they were concerned.
- An information board in the outpatient department displayed the names and role of staff within the department. Within the MRI suite we saw information booklets informing patients about what to expect during a MRI scan. The physiotherapy department had information cards about different clinical conditions. The information cards directed patients to a telephone line or a website if they required further information.

Emotional support

- Staff we spoke with had an understanding of the emotional impact care and treatment could have on patients. An example of this included staff in the booking department contacting a patient's GP to request a referral letter for a patient who was anxious about been seen promptly.
- We observed caring interactions between staff, patients and relatives. Staff reassured patients and relatives about the care and treatment they received. The majority of people we spoke with said they felt they received emotional support from staff, or this would be available if needed.
- A specialist nurse practitioner supported the oncology clinics and offered support to patients and families when receiving difficult news.
- Within diagnostic imaging, families and carers were invited to stay with patients during scans if a patient was particularly anxious. The family member or carer had to complete a safety questionnaire prior to been allowed to stay during a scan.
- The hospital had a policy in place for the use of staff trained as chaperones. Information about requesting a chaperone was displayed in the waiting areas and provided guidance on their availability to patients. Any patient who was undergoing an intimate examination had a chaperone and the hospital operated an opt-out system.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital engaged with the local clinical commissioning group and NHS trust to plan and deliver contracted services based on local commissioning requirements.
- The hospital provided consultation only (non-surgical, non-invasive) outpatient services and x-ray to children aged 0-18 years. Ultrasound scanning was available for children 5 years and over and MRI scanning for children 8 years and over. A bone density scanner and CT scanning was provided to young people aged 16 and 17 as part of the adult service.
- The hospital provided outpatient services for people of all ages. Between April 2015 and March 2016, 34 attendances were from children below two years old and 2,967 attendances were from adults aged over 75.
- Evening outpatient clinics were available for patients and diagnostic imaging could be booked up to 8pm.
- Both the outpatient and diagnostic imaging departments were situated on the first floor and could be accessed via a lift or stairs. The MRI unit was in a separate building, a short walk from the main hospital.
- Appropriate seating was available in both the outpatient and diagnostic imaging waiting areas. A raised-height chair was provided in each of the waiting areas for patients who had difficulty standing from low heights.
- We saw magazines and newspapers readily available in waiting areas and there was information displayed about how to connect to the hospital's internet.

Good

Outpatients and diagnostic imaging

- There were no children's toys but one corner of the outpatients waiting area had child appropriate posters. Staff said colouring books and crayons were available for children from reception on request.
- The disabled toilet in the outpatients waiting area was small. There was a larger disabled toilet that was more accessible on the ground floor. There was also an accessible toilet in the diagnostic imaging department.
- Free car parking was available with disabled spaces allocated close to the entrance of the hospital and the separate MRI suite.
- All departments were signposted however, signs appeared small and not dementia friendly or accessible for visually impaired people.
- All appointment letters sent to private patients included a charging sheet so they were fully aware of any charges before attending their appointment.
- We saw corporate Nuffield Health information displayed in waiting areas but no evidence of information in accessible formats. Staff said they could order corporate leaflets in other languages.

Access and flow

- Between April 2015 and March 2016, the hospital saw 18,142 outpatients in clinics of which, 7,399 were first appointments and 10,743 were follow up appointments.
- The hospital treated NHS and other funded patients and received the NHS referrals through NHS Choose and Book. Out of the 18,142 attendees, 4280 were NHS funded and 13,862 were other funded appointments.
- Between April 2015 and March 2016, the hospital met the referral to treatment time (RTT) waiting times for incomplete pathways indicator of 92% with the exception of May 2015 (89%), July 2015 (91%) and August 2015 (91%).
- During 2015/16, the provider did not consistently achieve the indicator of 95% for non-admitted patients beginning treatment within 18 weeks of referral. In April they achieved (86%), May (86%), July (82%), August (93%) and in October (91%). From December 2015 to March 2016, they had achieved above 95%.
- Managers told us the drop in RTT performance was due to an increased number of physiotherapy referrals. The hospital had voluntarily offered to accept these additional referrals to support the local clinical commissioning group to fulfil a contract.
- Patients had a choice for booking the dates and times of appointments. Patients we spoke with confirmed appointments were offered that suited their needs. None of the patients we spoke with raised any concerns about being able to access appointments in a timely manner or delays in clinic. We heard reception staff booking patients for future appointments; patients were all offered a choice of times and dates.
- The hospital did not collect data on waiting times however; staff in all departments told us the waiting times for appointments were short. The radiology manager and outpatient manager told us patients could get an appointment within a week. Staff said any patients needing an urgent appointment could be booked at the end of clinics.
- Waiting times for bone density scans were monitored and reported weekly to the local commissioners. Staff said the current waiting time was four to five weeks. Staff said additional clinic appointments could be made available to manage waiting lists to ensure the six-week target was met.
- From April 2015 to March 2016, there were 132 outpatient appointments where patients did not attend. This did not include diagnostics or physiotherapy appointments. The numbers of patients who did not attend were monitored but not formally audited.
- If a patient did not attend, staff would contact the patient to rearrange an appointment. If a child under 15 did not attend, staff said they would contact the parent or guardian.
- Within diagnostic imaging, between April 2015 and March 2016, there were 107 cancelled procedures. This equated to 2.3% of the total number of procedures.
- Between January and March 2016 there were two outpatient clinics cancelled. Staff said patients would be contacted and offered the next available appointment.
- Patients we spoke with were pleased with the choice, availability and timeliness of appointments and reported usually waiting less than five minutes when in

the department. There was a sign in the waiting area prompting patients to speak with the receptionist if they had been waiting more than 15 minutes. Waiting times in the department were not formally audited.

Meeting people's individual needs

- In the 2016 patient led assessment of the care environment audit (PLACE), the hospital scored 85.6% for dementia and 81.7% for disability. Staff told us the survey had highlighted a need for information in alternative formats such as large print and the lack of an accessible changing room in diagnostic imaging.
- Nuffield Health had a corporate dementia lead and the service had access to the hospital dementia link nurse who had undertaken specific dementia training.
- Hearing loops were available at the reception desks in outpatients and diagnostic imaging department.
- Hot drinks were available free of charge in the outpatient and diagnostic waiting areas and in the MRI suite. All departments had water machines that patients and visitors could access.
- We saw chaperones were available in the departments we visited. Staff in diagnostic imaging said chaperones were routinely provided on an opt-out basis for women undergoing mammography and ultrasound scans. A patient told us a chaperone was provided during their gynaecology appointment.
- Bone density scanning equipment was designed to accommodate bariatric patients.
- Diagnostic imaging staff described how they had adapted practice to meet individual needs in relation to patients with eating disorders. To avoid the distress of weighing patients prior to the scan, it was agreed that the referrer would document the patient's latest weight on the referral form.
- Male patients having intimate scans were given the option of a male radiographer.
- Information was provided in English and there was a system in place to access written patient information in other languages on request. There were policies for accessing interpreting services and interpreters were usually arranged prior to arrival by GPs or through the booking process. Staff were unaware of how to access interpreting support on the day if required. Staff said they rarely saw patients who required an interpreter and if a patient arrived without an interpreter they would rearrange the patient's appointment. Some staff described using relatives to interpret for patients.
- By 31 July 2016, all organisations that provide NHS care must have fully implemented and conformed to the Accessible Information Standard - to identify, record, flag, share and meet information or communication needs relating to a disability, impairment or sensory loss. The hospitals appointment system asked patients if any special assistance was required and appointment letters asked patients about access needs. The hospitals computer system was able to record and alert staff to additional needs. However this option was not consistently used which meant that staff might not be ready to meet communication needs and provide information in the appropriate format and in a timely way.

Learning from complaints and concerns

- The hospital had a complaints policy in place. Staff would attempt to resolve complaints at the earliest opportunity. Patient complaints followed a three stage process. Stage one involved acknowledging the complaint, explaining the process, an investigation and a response by the hospital within 20 days. If the complaint was not resolved it would be escalated to stage 2. This stage involved a corporate investigation. Stage 3 involved an independent review by the Independent Sector Complaints Adjudication Service (ISCAS), for other funded patients, or the Parliamentary and Health Service Ombudsman for NHS patients.
- Between April 2015 and March 2016, the hospital received 12 complaints. The number of complaints was lower than the average of other independent acute hospitals for which CQC hold data and very low for outpatients and diagnostic imaging. Only one complaint was related to outpatient and diagnostic imaging services. No complaints were referred to the Ombudsman or ISCAS. In response letters to complaints, we saw written evidence of an apology when things had not gone as planned.
- We saw evidence of complaints being discussed at weekly senior management team meetings and at heads of department meetings and integrated governance meetings.

Good

Outpatients and diagnostic imaging

- The service had processes in place for patients to raise concerns including the patient satisfaction survey questionnaire and the hospital website. 'How to make a comment or formal complaint' leaflets were displayed at various locations within the hospital.
- Complaints and any lessons learnt were recorded on the hospitals electronic reporting system. This enabled the hospital to produce a report and identify any trends.
- Examples of lessons learnt following a patient complaint included improved collaborative working with the local trust in order to enhance the patient experience and extended opening times of reception to accommodate people arriving early mornings prior to admission to the ward.
- Patients we spoke to were very positive about the service provided and had no complaints. Patients said they felt they would be taken seriously if they did need to complain and would feel confident to contact the hospital directly if they wanted to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The heads of departments in diagnostic imaging, outpatients and physiotherapy all had clinical roles and were easily accessible. Staff reported good support and guidance from their managers. Managers were passionate about their teams and caring for their patients.
- The senior leadership team was highly visible within the hospital. Staff spoke positively about the matron and hospital director and said they knew staff by their names and were very approachable. Staff described the senior leadership team as having an 'open door policy'. Staff felt able to confidently raise concerns and felt that they would be listened to and appropriate action taken.
- Between April 2015 and March 2016, rates of staff sickness within the outpatient department were lower than the average independent acute providers. In comparison to other independent acute hospitals, the rate of staff turnover was below the average within outpatient and diagnostic imaging.
- Staff told us they felt proud and part of the team they worked in. They enjoyed working for the hospital and felt supported in their roles. The hospital had an annual long service awards to recognise and celebrate staff. Staff also told us team working and communication was good and they felt confident to ask questions.
- All heads of departments told us they had monthly one to one meetings with the matron. This gave them the opportunity to discuss any concerns. We saw posters displayed in the MRI suite providing information about how to raise concerns and within the booking department, staff had a weekly 'huddle' to discuss and share any issues within the department.
- Hospital wide objectives were included as part of the staff's personal development process to encourage ownership of the trust values.

Vision and strategy for this this core service

- The Nuffield Health corporate vision, 'for the love of life' was in place and focused on six core beliefs. Staff we spoke with were aware of the corporate vision.
- Staff had attended 'for the love of life' forums to embrace the values and beliefs of the hospital. We saw a display board where staff had signed up to the hospitals values.
- Staff spoke passionately about the service they provided and the care they offered to patients but they were unable to articulate what the vision was for the individual departments that we visited.
- There was a local business plan in place for sustaining and expanding the services provided at Nuffield Health York Hospital incorporating governance and patient safety priorities. This included expanding the bone density scanning service, the MRI service and GP liaison to increase referrals.
- In the outpatient department, staff did talk about the department undergoing a refurbishment to improve the environment for patients; however, they were not familiar with a formal vision or plan in place to develop the service.

Good

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

See the Surgery section for main findings.

- The physiotherapy department described one of their top risks as errors on the booking system. They gave examples of patients attending for appointments that had not been booked on the system; however, these were not reported as incidents. Staff had reported the issue verbally.
- We reviewed meeting minutes from the outpatient department, radiology department and physiotherapy and saw evidence of discussion around patient incidents, documentation errors, lessons learnt, audits and patient experience.
- Governance arrangements within radiology were well established. Radiology had an on-site radiation protection supervisor who was responsible for ensuring local compliance. Arrangements were in place to seek advice from the radiation protection advisor in accordance with local rules. The radiation protection advisors supported quality assurance, governance, radiology local rules and local risk assessments. The corporate medical exposure committee oversaw the use of medical exposures at all sites within Nuffield Health.

Public and staff engagement

See the Surgery section for main findings.

- Patients had not been involved in the planned refurbishment of the outpatient department or the recently opened MRI suite.

Innovation, improvement and sustainability

- In diagnostic imaging, staff liaised with GPs and NHS providers to offer bone density scans to patients. The hospital was the only provider of this service within the local community of health service providers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure consultants record their assessments in the patient care pathway when visiting patients.
- The hospital should review the systems in place to ensure that the resident medical officers are included in communication about clinical governance concerns and the lessons learned to maintain and improve the quality and safety of the service.
- The hospital should ensure oxygen is prescribed on the medication administration record prior to administration.
- The hospital should review their systems for monitoring fasting times.
- The hospital should review their systems for monitoring the accuracy and completion of records.