Nuffield Health Leeds Hospital

Quality Report

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

Ratings

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

Overall summary

Nuffield Health Leeds Hospital is operated by Nuffield Health. The hospital has 88 beds and facilities include six operating theatres (two of which have laminar flow), a hybrid interventional suite, endoscopy and radiology services. The hospital provides surgery, critical care, children and young people and outpatients and diagnostic imaging services. We inspected each of these services.

We inspected this hospital using our comprehensive inspection methodology. We carried out the announced inspection 8 to10 February 2017, with an unannounced visit to the hospital on 22 February 2017.

Summary of findings

We rated surgery and outpatients and diagnostic imaging as outstanding and services for children and young people and critical care as good. We rated the hospital as outstanding 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 outstanding overall because:

- The leadership drove continuous improvement and motivated staff to improve the quality of care through professional development and innovation. Staff were proactively supported by management to acquire new skills and share best practice. Levels of staff satisfaction were high; they told us they felt well supported by management and were proud of the hospital, the positive culture and focus on quality improvement.
- Learning was based on thorough analysis and investigation of things that went wrong. The hospital utilised professional development resources to develop education programmes based on the outcome of investigations to improve patient safety related to diabetes management, catheterisation, medicines management and quality of documentation. Resulting changes were monitored through audit.
- The hospital maintained strong relationships with local healthcare partners and had active roles in areas such as antimicrobial stewardship, professional development and education. One outcome involved the development of the 'catheter passport' to improve the quality of catheter care after discharge from the hospital.
- The pre-assessment process included a full health assessment. During this assessment, staff were able to identify patients who were at risk of developing diabetes or cardiac conditions. We were told of patients diagnosed with conditions they were unaware of as an outcome of the health assessment. Patients were provided with an overall health report to discuss with their GP if required.
- Feedback from patients, family and carers in all services was consistently positive and we saw evidence of care exceeding expectations. The Friends and Family survey found that 99% of patients would recommend the hospital to others. Feedback from parents was particularly positive about the quality of care given to children.
- Staff demonstrated a proactive approach to understanding the needs of different groups of people and delivering care in a way that met those needs. For example, the recovery nurse met children before anaesthetic to reduce anxiety when waking up after surgery. There were excellent facilities for patients living with dementia in the outpatients department and a designated room adapted for ease of use for patients living with dementia on the ward.
- New evidence-based techniques and technologies were used to support the delivery of high quality care. For example, the hospital was the first independent hospital to use the spinal navigation system for spinal surgery and the radiology department had introduced a new service, CT colonography, which used low dose radiation CT scanning to obtain an interior view of the large intestine. Staff had received specific training in order to provide these services.

We found areas of good practice in surgery, critical care, services for children and young people and outpatient and diagnostic imaging:

Summary of findings

- There was a clear governance structure in place, with regular meetings held by all groups within the structure and effective reporting escalating to the hospital board and medical advisory committee.
- Risks were actively monitored through the hospital risk register at all levels of management and ways of reducing the risk investigated. Any changes in practice to reduce risk were monitored for compliance.
- There was proactive infection prevention leadership evidenced by improvement initiatives and a regular gap analysis against policy and procedures to monitor compliance. We saw there were actions in progress toalign withnational guidance for floor covering in clinical areas and clinical hand washing facilities where needed.
- The critical care team had developed a training programme on the management of a deteriorating patient; they provided this training to hospital ward staff and to staff at other Nuffield Health hospitals.
- There were clearly defined and embedded systems to keep people safe and safeguarded from abuse. Complaints were low in number and well managed.
- Staffing levels and skill mix were planned, implemented, and reviewed to keep people safe at all times. Staff shortages were responded to quickly.
- Consultant anaesthetists were responsible for their patients' care for 24 hours post-surgery. Outside of this timeframe, should there be a need for anaesthesia care, the patient would be transferred to the critical care unit and an intensivist identified to take over the patient's care.
- There was coordinated multidisciplinary working with all relevant staff involved in assessing, planning and delivering people's care and treatment. High quality performance and care were encouraged and acknowledged and staff were engaged in monitoring and improving outcomes for patients.
- Services were planned to ensure the needs of children and young people were met. Dedicated paediatric operating sessions were established and children and young people were not seen in clinic without appropriately trained staff being available. There were no waiting times for admission and treatment children and young people.

We found areas of practice that require improvement overall:

- Consultant documentation in the patient's record was not always timely, legible or clearly signed.
- Following a change in corporate training policy, paediatric resuscitation training levels for relevant staff were below target.
- Carpets were present in clinical areas; plans were in place for a refurbishment programme to remove these. Nuffield Health Leeds Hospital was built prior to the issue of the Department of Health guidelineson flooring in clinical areas where spillages may occur (Health Building Note 00-09: Infection control in the built environment, 2013).
- The hospital had established an informal agreement with the local NHS trust to accept patients to support their critical care needs. However, a formalised patient transfer arrangement was not in place.

We found areas of practice that require improvement in Critical Care

- The hospital did not participate in relevant national benchmarking databases to evidence patient outcomes in critical care or cardiac surgery.
- Audits of the critical care outreach service did not clearly identify the effectiveness of the service.

We found areas of practice that require improvement in services for children and young people:

- The hospital did not participate in relevant national benchmarking databases to evidence patient outcomes in paediatric surgery.
- Clinical hand washing facilities could be improved; plans were in place to install additional hand basins.
- We saw no evidence of Gillick competency assessments or of young people signing consent forms.

We found areas of practice that require improvement in the outpatient service:

Summary of findings

- Not all cleaning chemicals were stored safely and securely.
- Not all staff were aware of how to manage the hearing loop.

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	Outstanding ☆	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. The hospital has 88 beds and facilities include six operating theatres (two of which have laminar flow), endoscopy services and a hybrid interventional suite. We rated this service as outstanding for caring, responsive and well-led and good for safe and effective.
Critical care	Good ●	Critical care services were a small proportion of hospital activity. Where arrangements were the same, we have reported findings in the Surgery section. The hospital has an eight-bed critical care unit providing level 2 and 3 care. We rated this service as good for safe, caring, responsive and well-led and requires improvement for effective.
Services for children and young people	Good ●	Services for children and young people were a small proportion of hospital activity. Where arrangements were the same, we have reported findings in the Surgery section. The hospital has a nine-bed children's unit for day case and inpatient surgical care. We rated this service as good for safe, caring, responsive and well-led. We inspected but did not rate effective due to insufficient evidence being available for patient outcomes.
Outpatients and diagnostic imaging	Outstanding ☆	Services for outpatients and diagnostic imaging were a small proportion of hospital activity. Where arrangements were the same, we have reported findings in the Surgery section. We rated this service as outstanding for caring and responsive and good for safe and well-led. We inspected but did not rate effective as we are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostic Imaging services.

Summary of findings

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Outstanding ☆

Nuffield Health Leeds Hospital

Services we looked at
Surgery; Critical care; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Leeds Hospital

Leeds Hospital is operated by Nuffield Health. The hospital opened in 2002, having previously been located at another site on the outskirts of Leeds and primarily serves the communities of Leeds and surrounding areas. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since June 2002. At the time of the inspection, a new manager had recently been appointed and was registered in January 2017 as the registered manager (RM) and Controlled Drugs Accountable Officer (CDAO).

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Imogen Hall, 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 Leeds Hospital

Nuffield Health Leeds Hospital opened on 30th September 2002, having previously been located at another site on the outskirts of Leeds. It is located in the heart of the city centre and is a purpose built building over nine floors. Registered for 88 beds, 78 beds were operational at the time of the inspection including 70 beds used interchangeably between day case and inpatient admission. The remaining eight beds are located within the Cardiac Critical Care unit.

There are six operating theatres and a hybrid interventional suite. The hospital treats a broad range of specialties including: breast surgery; cardiology; cardiac surgery; cosmetic surgery; dermatology; ENT; gastroenterology; general surgery; gynaecology; haematology; neurosurgery; orthopaedics; spinal surgery; urology; plastic surgery; psychiatry and psychology.

Nuffield Health Leeds Hospital offer outpatient services to children and young people and surgical services to children and young people over the age of three only.

The hospital has a full on-site Clinical Pathology Accreditation (CPA) accredited pathology service including: microbiology; histology; biochemistry; haematology and blood transfusion. There is also a Medicines and Healthcare Products Regulatory Agency (MHRA) compliant transfusion service.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures (26 November 2010)
- Family planning (7 September 2015)
- Surgical procedures (26 November 2010)
- Treatment of disease, disorder or injury (26 November 2010).

Activity (October 2015 to September 2016)

In the reporting period:

- There were 7,843 inpatient and day case episodes of care recorded at the hospital; of these 63% were NHS funded and 37% were other funded (insured and self-pay).
- There were 36,125 outpatient total attendances and of these, 42% were NHS funded and 58% were other funded.

Staffing

- There were 321 consultants including surgeons, anaesthetists, physicians, and radiologists with practising privileges.

Summary of this inspection

- Two resident medical officers (RMO) worked on an alternate weekly rota and two RMOs worked on an alternate fortnightly rota to support care in the critical care unit and throughout the hospital.
- The hospital employed 71.5 whole time equivalent (WTE) registered nurses, 30.1 WTE care assistants and operating department practitioners and 139.4 WTE other staff, as well as employing its own pool of bank staff.

Track record on safety (October 2015 to September 2016)

- Two never events, following which actions were taken and lessons identified and shared.
- No serious incidents.
- There were 323 non-clinical incidents and 488 clinical incidents of which 342 caused no harm, 122 low harm, 22 moderate harm and none caused severe harm.
- There were two deaths (following post-operative transfer to an NHS trust).
- No incidences of hospital acquired Meticillin-Resistant Staphylococcus Aureus (MRSA), Meticillin-Sensitive Staphylococcus Aureus (MSSA) or Clostridium difficile (C.Diff).One incident of hospital acquired Escherichia coli (E.coli) infection related to antibiotic therapy.
- 19 unplanned transfers to an NHS hospital, 11 unplanned returns to the operating theatre and 8 unplanned readmissions. These numbers are not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- During 2016, we did not receive any direct complaints or whistle-blowing contacts for Nuffield Health Leeds Hospital. The hospital received 32 complaints in the reporting period.

Services provided at the hospital under service level agreement:

- Catering
- Facilities management
- Medical device servicing
- Waste collection
- RMO provision

We inspected surgery, outpatient and diagnostic imaging, critical care, and children and young people 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 received and reviewed information from the local commissioners. We placed comment boxes at the hospital before our inspection, which enabled patients to provide us with their views and received 130 comment cards.

We held one focus group meeting, 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 officer, radiographers and administrative and support staff totalling 91 personnel. We also spoke with 44 patients and relatives who were using the services. We observed care in the outpatient and imaging departments, operating theatres and on the wards and we reviewed 32 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 November 2013. This inspection found that the hospital met the standards of quality and safety that were inspected.

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:

- The hospital promoted a culture of openness and transparency, and reporting and learning from incidents. Incidents were fully investigated with actions for improvement identified and put into place. Opportunities to learn from incidents were identified, supported by educational modules by professional development. Resulting changes were monitored.
- Infection control was well-managed with effective audit tools and reporting mechanisms to monitor practice.
- Staff were clear about safeguarding practices and knew what actions to take if they had concerns.
- Medicines and contrast media were stored safely and medications requiring refrigeration were stored appropriately and at the correct temperature.
- There was a single set of fully integrated paper records for all patients with the exception of physiotherapy patient records, which were held on an electronic system. Records were stored securely and audited for compliance with documentation protocols.
- Surgical safety checklists were completed as required and a modified early warning score system was in place to support staff to recognise a deteriorating patient. Staff recognised and responded appropriately to changes in risk to people who used the service.
- The critical care team had developed a training programme on the management of a deteriorating patient; they provided this training to hospital ward staff and to staff at other Nuffield Health hospitals.
- The hospital had a compliance target of 85% for mandatory training. Most mandatory training levels achieved or exceeded target levels.
- Equipment specific to children's needs was available for use. Staffing levels met the RCN guidance on defining staff levels for children and young people's services.
- Staffing levels and mix were planned weekly and reviewed daily to keep people safe at all times. Staff shortages were responded to quickly.
- A pharmacist was present on the ward daily; they liaised with the medical and ward team regularly and attended the monthly ward staff meetings.

Summary of this inspection

- Consultant anaesthetists were responsible for their patients' care for 24 hours post-surgery and participated in an on-call rota. Consultants were accessible 24 hours a day or arranged alternate consultant cover.
- There was a senior manager on-call rota in place seven days per week. This rota was circulated and all staff were aware of the senior contact for the hospital each week.
- The hospital had a business continuity plan in place to respond to emergency situations and business continuity disruption.

However, we also found the following issues that the hospital needs to improve:

- Consultant documentation in the patient's record was not always timely, legible or clearly signed.
- Following a corporate training policy change, paediatric resuscitation training levels for relevant staff were below target. The senior management team were aware of this and plans were in place to be compliant across the hospital by the end of March 2017.
- Carpets were present in clinical areas; plans were in place for a programme to remove these.
- A formalised patient transfer arrangement with the local NHS trust was not in place.
- Not all cleaning chemicals were stored safely and securely.
- Not all staff were aware of how to manage the hearing loop.

Are services effective?

Good

We rated effective as good because:

- Patients had good outcomes as they received effective care and treatment to meet their needs. Care and treatment was planned and delivered in line with current evidence –based guidance, legislation and standards. Staff were aware of the guidance relevant to their area of work.
- Policies and procedures incorporating national guidance were in place and available to all staff in each of the services. Staff knew where to access guidance and policies.
- Children and young people's needs were assessed and care and treatment was delivered in line with legislation, standards, and evidence-based guidance.
- Staff were trained to ensure they were competent to provide the care and treatment needed. They were well supported by management and the professional development department to gain additional skills and consolidate learning. Appraisal levels were 100%.
- Staff skills and competence were monitored and staff were supported to obtain new skills and share best practice.

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- Consent to care and treatment was discussed and obtained in line with legislation and guidance.
- Staff could access the information they needed to plan and deliver care and there were effective discharge procedures in place.
- Monthly and quarterly local audits were carried out to monitor performance and patient outcomes. This information was used to monitor standards and improve care. Surgery participated in national audits and benchmarked performance.
- High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients.
- There was evidence of cohesive multidisciplinary working within all services.

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

- The hospital did not participate in relevant national benchmarking databases to evidence patient outcomes in critical care, cardiac and paediatric surgery.
- Audits of the critical care outreach service did not clearly identify the effectiveness of the service.
- We saw no evidence of Gillick competency assessments or of young people signing consent forms.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Quality of care was at the heart of the service and we saw evidence of care exceeding expectations across all services. Positive feedback was continual and particularly strong in services for surgery, children and young people and outpatients and diagnostic imaging.
- Examples of feedback included “staff were caring and professional”, “radiology team were so caring and patient”, “brilliant experience, I cannot fault it”, “everyone from reception staff to consultants treated me with respect and dignity”, “provided with full understanding of the treatment and side effects which was re-assuring” and “this is my second visit and the care is consistently excellent”. We were also told that “staff were busy but at no point did that impact on the quality of care”; “excellent service both times” and “staff were fantastic”.
- The children, young people and parents we spoke with told us that the care they had received was excellent. The nurses were described as “wonderful”, “lovely” and “amazing” with some

Summary of this inspection

describing them as “going above and beyond” and “nothing was too much trouble”. Parents we spoke with described all staff, including catering staff, porters and car parking staff as professional.

- The emotional needs of children and parents were embedded in the care provided. Recovery nurses introduced themselves to children before surgery to reduce anxiety when the children woke from anaesthesia. Parents were able to accompany their child to theatre and be present in recovery to give extra emotional support.
- Staff were committed to working in partnership with the patients; information was given to adults, children and young people in ways they could understand.
- Nursing staff could provide emotional support to patients receiving bad news and psychiatric support was available for patients receiving cosmetic, bariatric or breast cancer treatment.
- From April 2016 to January 2017, friends and family test showed an average of 99% of patients would recommend the service they received at Nuffield Health Leeds Hospital.

Are services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- The hospital maintained strong relationships with local healthcare partners and had active roles in areas such as antimicrobial stewardship, professional development and education and service improvement. One outcome involved the hospital developing the ‘catheter passport’ to improve the quality of catheter care after discharge from the hospital. The passport was recognised by all healthcare providers in the locality.
- People’s individual needs and preferences were central to the planning and delivery of services. For example, dedicated paediatric operating sessions were established and children and young people were not seen in clinic without appropriately trained staff being available. The lead paediatric nurse had devised information that explained the journey to the operating theatre and procedures with pictures for younger children.
- There was a proactive approach to understanding the needs of different groups including those in vulnerable circumstances such as people living with dementia. There was a dementia champion who attended meetings with other local providers to improve dementia care delivery. A quiet waiting lounge, separate to the main outpatient waiting areas, had been created with memory boards on the wall. Patients living with

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dementia were able to use this room if they were feeling unsettled in the main waiting area. Memory scrapbooks were also available. Patients with dementia or learning disabilities were able to have their carer or family member accompany them to theatre and be there when they woke up.

- Services were flexible, provided choice and ensured continuity of care. There had been major investments since 2014 including new MRI and CT equipment, spinal navigation equipment, orthopaedic stacks, a new operating table and patient telemetry equipment. Gym facilities were available free of charge for three months post-surgery for orthopaedic, spinal surgery and gynaecology patients.
- We were told that the hospital provided a private car service designed to assist self-pay or insured patients access the city centre hospital site. From initial consultation through to the first follow-up appointment, patients could be picked up and dropped off at the hospital as part of their package.
- Evening clinics provided good access to services for patients who worked full-time, meaning they did not have to take time off work to attend appointments. Patients could obtain appointments with very little waiting times. For example, physiotherapy appointments were available within 48 hours.
- There was no back log waiting list for endoscopy patients or interventional radiology. Patients were seen within three weeks of their referral.
- The pre-assessment process included a full health assessment. During this assessment, staff were able to identify patients who were at risk of developing diabetes or cardiac conditions. We were told of patients diagnosed with conditions they were unaware of as an outcome of the health assessment. Patients were provided with an overall health report to discuss with their GP.
- There was a low level of complaints and these were responded to in a timely manner. Any learning was taken forward to develop future practice.

Are services well-led?

Good

We rated well-led as good because:

- 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. Managers drove continuous improvement and motivated staff to improve the quality of care through professional development and innovation.

Summary of this inspection

- Frontline staff and managers were passionate about providing high quality care for patients. Staff told us they 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.
- There was a clear governance structure in place that functioned effectively and was understood by staff. All groups within the structure were well-attended and reported to the clinical governance committee chaired by the matron. The terms of reference of this committee were under review to reinstate consultant leadership for this committee. There was effective reporting escalating to the hospital board and medical advisory committee.
- Risks were actively monitored through the hospital risk register at all levels of management and ways of reducing the risk investigated. Any changes in practice to reduce risk were monitored for compliance. Local departmental risk registers were still being developed.
- Quality performance and activity was monitored through local and national audit processes and reported internally and corporately.
- Staff told us they attended a staff forum on a monthly basis with additional monthly engagement meetings held on the ward, which were minuted. Staff we spoke with told us they felt listened to, valued and were well supported through personal or ill health issues.
- Customer focus group meetings were held monthly. We saw in the minutes results of patient satisfaction surveys were discussed at these meetings.
- In order to gather the views and experiences of patients using their services, the hospital was planning to hold a patient forum group. We saw information displayed in waiting areas encouraging patients to take part.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Critical care	Good	Requires improvement	Good	Good	Good	Good
Services for children and young people	Good	Not rated	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Overall	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding

Notes

We were unable to rate the effectiveness of the Children and Young People service due to insufficient evidence.

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

Outstanding ☆

Surgery

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are surgery services safe?

Good ●

Incidents

- There were two never events between October 2015 and September 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. We reviewed the two Root Cause Analysis (RCA) and found each clearly identified the care and delivery problems, contributory factors, root cause identification, and lessons learned. They were of good quality, detailed and actions were completed within the required timescales. An example of an improvement action taken was the development of two e-learning modules on insulin management by the professional development lead at the hospital. These were disseminated to the hospital departments and protected time was allocated for staff members to complete the training modules. One module was to be completed by all clinical staff members and another specifically aimed at practitioners who prepare, manage and administer insulin. Clinical practice in insulin management continued to be monitored.
- The hospital confirmed they did not have any regulation 28 reports issued in the past 12 months. A regulation 28 is a report issued by a coroner where the coroner believes that action is required to prevent future deaths.
- Morbidity and mortality were discussed at monthly governance meetings as and when required.
- There were two serious incidents (SIs) reported to the Care Quality Commission (CQC) between October 2015 and September 2016. We saw thorough investigations had taken place, lessons were identified and acted upon.
- There were no SIs reported for endoscopy services or interventional radiology.
- There was no expected deaths and two unexpected deaths post-transfer to the NHS in the reporting period October 2015 and September 2016. We saw investigations had taken place and lessons learnt including actions implemented to manage the risk of venous thromboembolism (VTE).
- Incident reporting highlighted 124 instances where allergies were not clearly documented on the prescribing document used. Managers were aware of this through their own documentation reviews and actions had been taken to improve the recording of allergies. There had been an improvement following the action taken. We checked 10 records at random and found all of them to be correctly completed.
- No Statutory Notifications were made to CQC between October 2015 and September 2016.
- There were 37 clinical incidents reported for surgery between October 2015 and September 2016.
- Senior staff stated that all staff were aware of their responsibilities and all knew how to use the electronic incident reporting system to record and grade the severity of an incident. Staff raised concerns with their

manager and a decision was made together regarding the severity of the incident to be recorded. All incidents reported were discussed monthly at the department meeting.

- Staff members were familiar with the process for duty of candour. Senior management explained that patients were advised verbally when an incident had occurred and following investigation, patients were informed of cause, investigation, and outcome and given an apology in writing. Staff received feedback from all investigations from the ward manager on a one-to-one basis and at ward meetings. We saw letters of apology and explanation sent to patients, which were empathic and comprehensive.
- We heard evidence and examples of lessons learned. One example related to a patient developing a deep vein thrombosis (DVT). We saw the incident recorded appropriately and investigated thoroughly. The lessons learned were identified (to ensure re-assessment of VTE risk took place within 24 hours) and disseminated to staff at the ward round, safety huddle and on a one-to-one basis.

Clinical Quality Dashboard or equivalent

- The hospital populated a monthly Quality and Safety Dashboard, reported quality and safety indicators monthly to the local CCG, and completed the quarterly corporate quality performance report.
- There were no catheter urinary tract infections and no pressure ulcers reported from October 2015 to September 2016.
- There were eight surgical site infections (SSIs) reported between October 2015 and September 2016. The rate of infections following primary hip arthroplasty, spinal and cardiothoracic procedures was above the rate of other independent acute hospitals when compared to the data held by CQC. The rate of infections following primary knee arthroplasty procedures was below the rate of other independent acute hospitals.
- There were no surgical site infections resulting from revision hip arthroplasty, revision knee arthroplasty, other orthopaedic and trauma, breast, gynaecology, upper gastrointestinal and colorectal, urological, cranial or vascular procedures.
- The venous thromboembolism (VTE) screening rate in each quarter of the reporting period was 100% from October 2015 to September 2016 (95% targeted rate of screening for NHS contracts). There were three instances of VTE in the same period.
- Slips, trips and falls assessment completion rates were 99% which met the hospital target.

Cleanliness, infection control, and hygiene

- All elective patients undergoing surgery were screened for Meticillin Resistant Staphylococcus Aureus (MRSA), which was part of the pre-assessment process. If there was a positive result a patient would have five days treatment followed by three screens before any surgical procedure would be considered. Compliance rates were 100%.
- There had been no incidences of MRSA, no incidences of Meticillin Sensitive Staphylococcus Aureus (MSSA) and no incidences of Clostridium Difficile (C.Diff) reported between October 2015 and September 2016.
- Nuffield Leeds reported details of health care associated infections on a monthly basis. Audits showed that there was one incident of Escherichia coli (E.Coli) between October 2015 and December 2015.
- Nursing staff undertook sepsis training and ward managers were aware of the local microbiology protocols for the administration of antibiotics. The hospital had antimicrobial guidelines that mirrored the local NHS trust's prescribing practices providing evidence of cross partnership engagement and working.
- Nuffield Health Leeds Hospital had implemented a Commissioning for Quality and Innovation (CQUIN) for antimicrobial stewardship and conducted quarterly audits and assessment of practice which was fed back to clinicians and prescribing departments. There were strong links with the antimicrobial stewardship steering group at the local trust and the hospital was a member of the Leeds-wide antimicrobial stewardship strategy group. Hand hygiene audits in 2016 showed 67% compliance in endoscopy, 77% compliance for the ward areas and interventional radiology, 80% for theatres and 87% for pre-assessment. An action plan was in place to improve compliance.

Surgery

- Systems were in place to prevent surgical site infections. The service had an Infection, Prevention, and Control (IPC) lead within the department and there was a specialist IPC nurse for the hospital.
- All staff had IPC and aseptic competency training and each department had IPC link practitioners who ensured all training was up to date. Asepsis is the state of being free from disease-causing contaminants.
- The hospital participated in the NHS safety thermometer and Patient Led Assessments of the Care Environment (PLACE). PLACE scores showed 98% compliance in cleanliness.
- We saw ward cleaning schedules which included a full environmental clean daily, followed by further checks during the day to meet cleaning needs; a six monthly curtain change and steam clean and an annual environmental intensive deep clean. We saw hand washing areas in corridors and each patient's bathroom. There were hand gel facilities on the wards and we observed staff follow hand hygiene procedures appropriately.
- All equipment was observed to be clean and 'I am clean' stickers were used to identify clean equipment.
- Decontamination of surgical instruments audits showed 98% compliance rates over the 12 month period from October 2015 to September 2016.
- There were embedded decontamination processes in place for endoscopy. Staff stated they followed the policy in place to ensure all scopes were thoroughly cleaned. However, staff were fully aware that due to the layout of the unit, there was no separate clean entry point for decontaminated endoscopes. We observed that processes were in place to prevent cross-contamination with used endoscopes and there were plans in place to create a purpose built suite on the fourth floor which would support Joint Advisory Group on GI Endoscopy (JAG) accreditation.
- Legionella risk assessments had been completed in accordance with the Health and Safety Executive Approved Code of Practice and guidance on regulations.

Environment and equipment

- The areas we visited were visibly clean and tidy, however storage areas containing cleaning chemicals were not locked at the time of inspection. The matter was raised during the inspection and action taken to secure these items.
- We saw good arrangements implemented for managing waste and clinical specimens to ensure people were kept safe.
- All electrical equipment had undergone a safety test and was up to date.
- We saw personal protective equipment (gloves, aprons and wipes) were available and being used appropriately.
- We saw that the hospital had a reliable system for sterilisation of instruments. A fast track system was in place for specific instruments and safety measures were in place for coding and labelling to the sterilisation facility for re-useable medical devices (surgical instruments). There were several equipment deliveries each day. We were advised it was very rare that an operation would be cancelled because of lack of instruments.
- A medical devices team managed the loan equipment. If there were problems with the quality of decontamination, the kit was returned straight away. Records of this were kept in theatre.
- There was a traceability process for theatre surgical trays. All were tracked and could be traced using 'med-track' forms.
- We found bariatric surgery was carried out with safe and appropriate equipment for the patient group.
- The maintenance team responded seven days per week to fix broken or defective equipment.
- We saw that instruments, equipment, and implants complied with Medicines and Healthcare Regulatory Authority (MHRA) products requirements. There were processes for providing feedback on product failure to the appropriate regulatory authority via the medical advisory committee.
- All facilities, surgical and anaesthetic equipment including resuscitation and anaesthetic equipment were available, fit for purpose and checked in line with professional guidance.

- There were 19 scopes available for use in the endoscopy department. This meant that patients did not have to wait for scopes to be cleaned before use.
- All equipment for interventional radiology was relatively new and in full working order. We were advised that a previous malfunctioning piece of equipment was reported and replaced immediately.

Medicines

- The hospital had an in-house pharmacy with three trained pharmacists, two technicians and an assistant. A pharmacist was present on the ward daily, liaised with the ward team regularly and attended the monthly ward staff meetings. They monitored stock levels, management of controlled drugs and storage of medication in refrigerated units. We saw the fridge temperatures were recorded regularly and within the correct limits.
- Controlled drugs (CD) were checked and managed appropriately. The pharmacy department performed a two person quarterly audit of controlled drugs records. We found that CD audit action plans required updating. All controlled drugs were stored in appropriately locked cabinets. A medicine security audit undertaken in March 2016 raised no concerns with compliance. Staff were required to attend training and complete the e-learning safe medication programme prior to being able to administer these drugs and were encouraged to report errors in an open and honest way.
- Pharmacy carried out daily checks of prescriptions and reported pharmacy interventions when prescriptions were found to need amending or changing. We were told that the pharmacist would report repeated anomalies directly to the RMO, consultant or the Medical Advisory Committee if required.
- We found that 69 missed doses of medicines had been recorded between October 2015 and September 2016 related to prescribing standards. All incidents were reported through the hospital reporting system. We discussed missed medication doses with the pharmacist who advised that monthly audits were undertaken and an action plan was in place which monitored trends and themes. For the trend of missed doses, information was provided to the medical advisory committee chair who spoke to the consultant involved. There was an improvement following the action taken. We checked 10 records at random and found all of them to be correctly completed.

Records

- We reviewed 10 patient records and found all were stored securely and no patient identifiable information was visible to people attending the ward. All records were paper files.
- We found a variable standard of documentation on surgical wards with written records of pre-assessment in anaesthetic and nursing notes. Consultant daily entries were variable in consistency and quality. The hospital monitored consultant entries via quarterly audits of documentation standards and had raised these concerns with individual consultants.
- All patient records contained admission records, medicine chart, pre-assessment information, risk assessment and nursing notes. Not all documents were legible, signed or dated. Managers were aware of this and actions had been taken to improve the legibility of recorded information. Specific concerns were addressed with the relevant consultant.
- We saw adapted WHO checklists in use in the endoscopy and interventional radiology departments. Information recorded was appropriate and legible.
- The health records standards audit October 2015 and September 2016 showed 88% of records were completed appropriately. Action plans were in place to improve recorded entries. Discussions were held with staff and reminders sent by email about the quality of recording.

Safeguarding

- The hospital had no safeguarding incidents from October 2015 to September 2016 and there were no safeguarding concerns raised by or against Nuffield Health Leeds Hospital.
- All safeguarding training was undertaken through mandatory training. We found that 89% of staff had received safeguarding vulnerable adults level one training and that 89% of ward staff and 70% of theatre

staff had received safeguarding children and young adults level two training against the hospital target of 85%. Work was underway to ensure that compliance levels were reached by 31 March 2017.

- The overall safeguarding lead was the matron. The matron and deputy matron held level three safeguarding training for adults and children. The lead Registered Children's Nurse was responsible for networking and linking with the local Safeguarding Board contacts.
- The medical staff were aware of how to report safeguarding issues and relayed the process with confidence when asked.
- When we spoke with nursing staff, they demonstrated a good level of knowledge in relation to safeguarding triggers, forms of abuse and the processes followed.
- We saw information available to staff and patients regarding Female Genital Mutilation (FGM), Child Sexual Exploitation (CSE), staff guidance, process, and procedure.

Mandatory training

- The hospital training performance for the surgical services showed mandatory training completion results were predominantly above the hospital target of 85%.
- Ward staff had met most training targets: Incident reporting training (86%), fire safety (90%), health, safety and welfare (92%), managing stress (87%), whistleblowing (97)%, infection prevention: practical (81%), and information governance (89%). At the time of inspection, we saw that the Basic Life Support (BLS) training compliance rate in the surgical service was 71%, Intermediate Life Support (ILS) was 86%, Paediatric Basic Life Support (PBLS) was 66% and Paediatric Intermediate Life Support (PILS) was 22% (2/9 staff).
- Hospital management had experienced difficulty in arranging resuscitation training in the past year and were fully aware of the need for improvement in compliance. In addition, there had been a change in policy around paediatric resuscitation training resulting in more staff requiring training. Further courses were scheduled for February and March 2017 to improve training compliance rates.
- Theatre staff had met most targets: whistleblowing (100%), fire safety (94%), health, safety and welfare (94%), incident reporting training (85%), information governance (85%), infection prevention: practical (81%) and managing stress (80%), We saw that BLS training compliance was 75%, ILS was 47%, PBLS was 24% (8/33) and PILS was 18% (3/17).
- All pharmacists were up to date with their training and had completed Immediate Life Support (ILS) training. The staff nurse in the interventional radiology suite had completed Advanced Life Support (ALS) training.
- Senior managers told us that training programmes were embedded due to Nuffield Health Training Academy programmes.
- Clinicians employed by the local NHS trust underwent training through their trust and reported training outcomes to Nuffield Health through appraisal.

Assessing and responding to patient risk

- 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.
- A resident medical officer (RMO) trained in advanced life support (ALS) 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. There were also eleven critical care staff with ALS training who supported the cardiac arrest team.

- Four ward and theatre staff members held ALS training including the ward manager, theatre manager and two senior registered nurse in theatres. A further three theatre staff were booked on the ALS course in June 2017.
- The hospital used the Modified Early Warning Score (MEWS) risk assessment system. This allowed staff to record observations, with trigger levels to generate alerts, which helped with the identification of acutely unwell patients. Audit of MEWS score completion rate showed compliance of 100% between October 2015 and September 2016.
- A sepsis screening tool was in place fort staff to follow. Staff were aware of the criteria that would indicate when the sepsis screening tool needed to be completed. Following an incident with triaging a potentially septic patient via the telephone, the hospital developed and designed a telephone pathway for the quick detection of a septic patient. A staff education package supports this process and all clinical staff were required to complete an e-learning package on recognising the signs of sepsis.
- The hospital ensured compliance with the Five Steps to Safer Surgery through application of the National Patient Safety Agency surgical checklist (including instrument count, implant number, and recovery care). We observed the Five Steps to Safer Surgery including the theatre safety briefing and completion of safety checklists in practice and were satisfied with the process.
- The surgical safety checklist audit showed a completion rate of 95%. We chose 10 records at random and found all had fully completed surgical checklists.
- Staff obtained complete basic information by telephone during the initial contact. Further information was gathered when the patient presented for appointment. Staff gave an example of a patient who was unable to attend and received a comprehensive telephone screening and assessment by a qualified nurse.
- Multidisciplinary bed management meetings were held daily to consider the flow of patients. There were additional discussions about patients with particular needs or risks, equipment needs, medication management, transfers and discharge planning.
- Staff we spoke with were able to discuss and describe Nuffield health sepsis bundles, early warning concerns, and appropriate actions to take when sepsis is suspected.
- Nuffield Health Leeds Hospital accepted patients who were suited to the services provided. These were predominately low risk patients; however, the hospital was able to accept more complex patients for procedures such as craniotomies, complex spinal surgery and cardiac surgery as the service provided Level 3 critical care.
- There were established pathways in place for endoscopy and interventional radiology in the event of any complications or deterioration of the patient. There was a resuscitation trolley based outside of the endoscopy department and access in an emergency was timely.
- Consultant anaesthetists were responsible for their patients' care for 24 hours post-surgery. Outside of this timeframe, should there be a need for anaesthesia care, the patient would be transferred to the critical care unit and an intensivist identified to take over the patient's care.
- Longstanding customary arrangements were in place to manage emergency transfers to the local NHS trust; however discussions were ongoing to establish a formal service level agreement.
- If a patient was thought to require a transfer to an acute hospital, the RMO and consultant would review them in the first instance. The consultant made the decision, spoke with the accepting medical team and ward at the local acute hospital and provided a verbal handover. Written information followed with the patient. Once a patient was transferred, the admitting consultant became responsible for the patient.
- 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. We saw evidence that mock haemorrhage scenarios were undertaken under the supervision of the critical care unit manager.

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, nurses to patient ratio; however staffing levels during the day were most often a ratio of 1:6 as demonstrated by rotas viewed during the inspection. The number of nursing staff increased dependent upon patients' needs. Theatres used the Association for Perioperative Practice (AFPP) staffing guidelines.
- Staffing levels were calculated on a weekly basis to meet expected patient levels. The nurse in charge of each shift was supernumerary and had no patient load, which allowed time to review the next day's lists and staffing. The ward manager had three clinical and two non-clinical days based on the ward and was available to provide help and support if it was required.
- We found that actual staffing levels were in line with planned staffing levels during the inspection. We received six rotas between October 2015 and September 2016 and observed the same findings.
- There were three full time equivalent (FTE) posts vacant for theatre nurses giving a vacancy rate of 12%. There were 4.8 FTE posts vacant for theatre operating department practitioners (ODPs) and health care assistants giving a vacancy rate of 24%. The vacancy rate was higher than average compared with data held for other independent acute hospitals and the hospital was actively recruiting to the posts. There were two FTE posts vacant for inpatient nurses and 3.8 FTE posts vacant for other staff. The rate was lower than the average rate of other independent acute hospitals.
- The endoscopy department was fully staffed with a manager, two staff nurses, a health care assistant, and a porter.
- Sickness rates for theatre nurses, theatre ODPs and health care assistants were variable throughout the reporting period (October 2015 to September 2016). Rates were higher than the average of other independent acute hospitals for five of the 12 months. The rate of theatre nurse, ODP, and health care assistant turnover was also higher than the average of other independent acute hospitals in the reporting period.
- The use of bank and agency nurses in theatre departments was similar to the average of other independent acute hospitals in the reporting period.
- The use of bank and agency ODPs and health care assistants in theatre departments was lower than the average of other independent acute hospitals in the same reporting period, except from July to September 2016. All bank staff completed an induction plus medical devices training.
- The ward organised handover sessions with one team of staff three times per day (07:30, 12:30, and 19:30). During handover, staff discussed patient lists with the resident medical officer (RMO) and ward manager. This included discussion about individual patient needs, dietary requirements, surgical list orders and any risks and after care needs.
- There was an out of hours on call system which started on the ward regarding who makes the call to the consultant and theatre staff. The RMO attended the night-time handover and received a printed list of all patients.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems out-of-hours including medical staff.
- There was a senior manager on call rota in place seven days per week. This rota was circulated and all staff were aware of the senior contact for the hospital each week.

Medical staffing

- There were 321 consultants with practising privileges at Nuffield Health Leeds Hospital. 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.
- There was a total of four Resident Medical Officers (RMO) and an RMO onsite 24 hours a day, seven days a week. Two RMOs alternated one week on and one week off to cover the hospital and two covered the critical care unit. There was provision of an on-site residence for the RMO.

- Each RMO on duty was Advanced Life Support (ALS) and Paediatric Advance Life Support (APLS) trained and was available for assistance 24 hours per day, 7 days per week.
- We were unable to observe the weekly handover between RMOs. Informal handovers between nursing staff and the RMO and between consultants and the RMO occurred during the shift as required.
- 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.
- Staff we spoke with described the procedure for on-call arrangements for anaesthetists or surgeons out of hours. When the RMO and nursing staff needed to seek 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 lived outside the 30 minute 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.

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.
- Potential risks were taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.
- Arrangements were in place to respond to emergencies and major incidents such as fire, flood, loss of vital services, bomb threats, pandemic flu and severe adverse weather conditions.
- 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.
- Call bells were tested daily and fire alarms tested weekly. There was a weekly crash call test.

Are surgery services effective?

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 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.
- Nuffield Health Leeds Hospital rarely received patients with mental health conditions. However, staff were aware of the rights of people subject to the Mental Health Act (MHA). They advised they would speak with the Matron if they were uncertain.

- Patients assessed to be at risk of Venous Thromboembolism (VTE) were offered VTE prophylaxis in accordance with NICE guidance. The VTE audit showed 100% compliance between October 2015 and September 2016.
- Reports detailing significant incidents were discussed at meetings of the clinical heads of department, clinical governance committee, hospital board and medical advisory committee. Patients provide feedback through a patient satisfaction survey, which was cascaded to staff; action plans were completed addressing areas of concern. Matron also completed succinct summaries for distribution to staff.

Pain relief

- Nurses discussed pain relief with elective patients at pre-assessment and provided information on the type of pain relief that patients could expect to receive as part of their procedure. Patients were given information leaflets on pain relief.
- Patients told us that when they experienced physical pain and discomfort the staff responded in a compassionate, timely, and appropriate way. We were advised that pain scores were checked regularly.
- The Modified Early Warning Score assessment included a pain score, which was reviewed at every assessment and comfort checked regularly throughout the day and night.
- Pain was monitored by the named nurse who could access support from an anaesthetist if required. On discharge, the Registered Medical Officer (RMO) discussed and reviewed pain medication with the patient and would prescribe as necessary.
- Ward pharmacists regularly reviewed drug records for pain medication. Various pain relief methods were used for major surgery to assist with pain relief post-operatively, which improved patient comfort.

Nutrition and hydration

- Patients nutrition and hydration needs were assessed during the pre-assessment consultation. Food allergies were recorded and highlighted by providing a red wristband for patients to indicate an allergy. Kitchen staff and theatre staff were also made aware.
- Patients using services had access to dietician services post operatively if required, via the relevant acute NHS trust. Patients receiving bariatric surgery had access to a dietician from the acute trust prior to any surgical procedure taking place at Nuffield Health Leeds Hospital. Further dietician involvement was available via the GP and consultant.
- Pre-assessments provided all elective patients with fasting instructions to follow on the day of their surgery.
- We observed domestic staff attend safety huddles so that they were fully informed of patient nutritional needs, such as patients fasting or those with specific dietary needs.

Patient outcomes

- All patients for joint replacement surgery were asked at pre-assessment to consider being registered for the National Joint Registry (NJR); this monitors infection and revision rates. Patients were also given the opportunity to participate in Patient Reported Outcome Measurements (PROMs) data collection for hip replacement, knee replacement, varicose veins, and inguinal hernia. The hospital had recently taken part in an electronic PROMs reporting pilot scheme in addition to the above.
- EQ-5D Index for primary knee replacement (Generic health status measure) informed that out of 138 modelled records 81.9% were reported as improved and 8% as worsened (April 2015 to March 2016). This was similar to the England average.
- EQ-VAS for primary knee replacement (Visual Analogue Scale component of the EQ-5D) informed that out of 120 modelled records 55% were reported as improved and 33.3% as worsened (April 2015 to March 2016). This was similar to the England average.
- Oxford knee Score informed that out of 149 modelled records 95.3% were reported as improved and 4% as worsened (April 2015 to March 2016). This was similar to the England average.
- EQ-5D Index for primary hip replacement (Generic health status measure) informed that out of 91 modelled records 91.2% were reported as improved and 2.2% as worsened (April 2015 to March 2016). This was similar to the England average.

- EQ-VAS for primary hip replacement (Visual Analogue Scale component of the EQ-5D) informed that out of 88 modelled records 72.7% were reported as improved and 14.8% as worsened (April 2015 to March 2016). This was significantly higher than the England average.
- Oxford hip score informed that out of 98 modelled records 99% were reported as improved (April 2015 to March 2016). This was similar to the England average. The hospital's adjusted average health gain for PROMs for Groin Hernia could not be calculated as there were fewer than 30 modelled records.
- The hospital participated in the Public Health England surgical site surveillance programme (PHE SSI programme) in the following categories: hip surgery (mandatory), knee surgery (mandatory), cardiac arterial bypass graft surgery (voluntarily reported). The hospital monitored breast and spinal surgery surveillance internally. All data was collected via a 30 day phone call after the procedure or through intelligence data collected from outpatients, physiotherapy, returns to the ward and through external links with the local trust to identify readmissions at other hospitals
- Most patients who underwent joint replacement surgery were reviewed in clinic. For patients funding their own procedures, the terms and conditions offered support for any untoward outcomes relating to surgery for an indefinite length of time without additional cost to the patient. The governance framework ensured that a range of outcomes were reviewed and discussed.
- On a monthly basis there was a report submitted to the corporate quality manager; this reviewed benchmarked data across the company. Hospital associated infections were uploaded onto a corporate clinical website, and hip and knee arthroplasty surgical site infections reported to Public Health England. The hospital was working within the expected targets.
- The new breast implant registry was implemented at Nuffield Health Leeds Hospital from October 2016. The hospital also kept records of breast implants; this information was collated at the time of surgery and documented in the theatre implant record book. The hospital did not participate in the Anaesthesia Clinical Services Accreditation Scheme (ACSA) or collect Q-PROMs for patients receiving cosmetic surgery.

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 October 2015 to September 2016. All staff we spoke with thought the appraisal process was useful and provided opportunity for development.
- New staff had an induction relevant to their role. Newly qualified nurses were supported through preceptorship programmes by being allocated a mentor during their preceptorship.
- Bank nurses received an orientation and induction to the ward area by following an induction checklist. This included the use of resuscitation equipment and medicines management.
- The resident medical officers (RMO) 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 when required. 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 General Medical Council guidance and completed by a medically qualified appraiser. The hospital team worked closely with nearby NHS trusts 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.

- To improve competency, staff had access to a catheterisation training session held monthly, e-learning modules in diabetes management and support from the professional development lead after medication errors including a medicines management competency programme. A neurosurgeon provided three educational sessions on the care of patients undergoing spinal surgery which had been attended by 57 staff members.
- The hospital had a structured and well established network with local universities to provide a variety of student placements within the ward, theatres and diagnostic imaging. Feedback stated that the hospital was able to meet the standards set by the Nursing and Midwifery Council and provided a high quality student experience. The hospital actively encouraged students to participate in monthly 'student forums' to provide constructive feedback and suggestions.
- 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.
- 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

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. Care was coordinated between pre-assessment, wards and theatre staff, radiology and physiotherapy ensuring all teams was involved in effective care delivery.
- The pre-assessment team advised us that information was sent to the ward regarding details of any special requirements for the patient; for example, if the patient lived alone or needed a special mattress.
- We found handover and transfer processes in place to ensure consistent multidisciplinary care delivery when people were moving between teams or services, including referral and discharge.
- The ward staff at Nuffield Health Leeds Hospital liaised with local trusts, local authorities and GP's to ensure the arrangements for discharge were considered prior to elective surgery taking place.
- Handover processes were in place to ensure the Resident Medical Officer (RMO) received appropriate information about the patients and the surgery undertaken. This also ensured that all team members were aware of who had overall responsibility for each individual's care.
- District nurses were involved in discussions prior to discharge to ensure the patient received continuity of care. The GP received a copy of the discharge letter sent to them on the same day of discharge. Details of surgery and implants used remained with the hospital.
- Staff advised that there was good multi-disciplinary working in the endoscopy department. Staff had worked within the department for a long time and had established good communication and working relationships.

Seven-day services

- Basic haematology and biochemistry tests were performed on-site; out of hours, pathology staff provided on-call telephone cover. The hospital had a blood transfusion service managed by an electronic tracking system. The local NHS trust could also supply blood products to the department on a use or return basis to minimise wastage.
- Consultants (surgeons, anaesthetists and physicians) were required to be available within a thirty minute radius of the hospital for the duration of their patient's stay or ensure suitable cover was provided. They had direct access to the ward through a dedicated mobile telephone. Intensivist and anaesthesia services were accessible 24 hours a day.

- There were two Resident Medical Officers (RMO) on-site, one of whom was experienced in anaesthesia and critical care. The agency providing RMOs ensured standby cover could provide an immediate replacement if an RMO had experienced extensive work commitments during a 24 hour period or became unwell.
- Access to physiotherapy services was available seven days a week, as in-patient physiotherapy was provided from 9am-4pm on a Sunday, with emergency cover outside of this time.
- On-site pharmacy services were provided 8.30am to 4:30pm each week day, from 9am-1pm on Saturdays and via on-call provision from 4pm Saturday until 8am Monday. 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 via the pharmacy on-call service.
- A senior nurse was on duty at all times on the ward (designated as the Site Co-ordinator during out-of-hours). There was a clinical on-call rota for the wards covered by senior nursing staff (Sister level and above) and a Senior Management Team on-call rota.
- A daily locator identified the resuscitation team members, the fire incident co-ordinators, and the paediatric nurse on duty. There was also an on call theatre team, radiographer, pharmacist and pathology staff.
- There was no on-site Occupational Therapy service on site but this was accessible if required.

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. Staff, including bank and agency staff, had easy access to policies, procedures and guidance through the hospital intranet and multiple resource folders held at the nurses station.
- We found that when patients moved between teams and services, including at referral, discharge, transfer and transition, all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols.
- Discharge was communicated to GPs by fax or letter on the day of the patient discharge. We found that GPs had direct access and could speak to a surgical team for advice on the phone as required.
- Handovers were undertaken twice daily to share information and a safety huddle took place early morning to discuss new patients and discharges.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that most patients had consented to surgery in line with the hospital policy and Department of Health guidelines. We were informed that patients did not sign the consent form at the first appointment to allow for a period of reflection as per the Professional Standards for Cosmetic Surgery 2016. Patients signed the consent form at the second appointment. However, some patients did not attend the second appointment and therefore gave consent on the day of surgery.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. We found that 93% of theatre staff had completed Mental Capacity Training and 91% for Deprivation of Liberty safeguarding training. Ward staff had achieved 96% training completion rates for both MCA and DoLS training.
- We found policy and procedures in place and that capacity assessments and consent was obtained by the appropriate clinician. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications.
- Consent for the breast implant registry was sought at pre-assessment, completed by the theatre team and surgeon and then uploaded to the website by the theatre administrator. The paper copies were kept within the theatre department.

- Staff said they would speak to the GP and/or family if there were concerns regarding capacity. Staff reported that they would support patient and family through the best interest's decision making process where required.

Are surgery services caring?

Outstanding ☆

Compassionate Care

- We spoke with 12 patients who were consistently positive about the service they had received at the hospital. All patients said they would return for surgery in the future if required and would recommend friends and family.
- Friends and family test showed results of 99% of patients were happy with the service they received at Nuffield Health Leeds Hospital in September 2016.
- We received completed comment cards from 27 patients. All 27 cards were positive and complimentary about the service, care and treatment received as a surgical patients.
- Feedback included "I have received an outstanding and professional level of care from my treatment and stay in hospital"; "staff were caring and professional"; "very caring and attentive"; "provided with full understanding of the treatment and side effects which was re-assuring" and "this is my second visit and the care is consistently excellent". We were also told that patients were "treated with dignity and respect"; "staff were busy but at no point did that impact on the quality of care"; "excellent service both times" and "staff were fantastic".
- We were advised of a visually impaired patient who had day surgery planned but was changed to an overnight stay due to the need for diabetes management. This change improved the patient's wellbeing and experience.
- We saw staff take the time to interact with people who use the service in a respectful and considerate manner. They were encouraging, sensitive, and supportive towards patients and sought consent prior to our discussions with patients.
- All patients had drinks and call buzzers located within easy reach. Patient told us that staff did not take long to answer call bells. During the inspection, we saw call bells were answered promptly.
- We observed staff ensure people's privacy and dignity were respected during physical and intimate care at all times. Patients had single rooms and had access to ensuite bathrooms.
- We were advised that patients with disabilities were provided with a chaperone to support and assist them through the process and treatment of interventional radiology.

Understanding and involvement of patients and those close to them

- All patients said they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients and relatives said they felt involved in their care and had been given the opportunity to speak with the consultant and anaesthetist looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out and did their best to keep patients reassured.
- We saw that ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- Patients we spoke with were complimentary of the patient information booklets given prior to surgery. Patients felt they were better educated, supported and prepared for their surgical procedures.
- People were advised about all possible costs that would be incurred in a timely manner at the initial consultation, again at pre-assessment and on admission. Financial contracts were signed at pre-assessment.
- We saw patients 'pop in' to the hospital with queries about their care needs post operatively and staff told us of examples of patients returning to hospital to have dressings changed when they had concerns.
- During the inspection we spoke with a patient who had presented at the hospital without appointment because

they were concerned about a dressing on their leg (post-surgery). We were advised the resident medical officer met with the patient, checked the wound and changed the dressings to provide reassurance.

Emotional support

- Staff spoke compassionately about their patients and had a clear understanding of the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.
- People were given appropriate and timely support and information to cope emotionally with their care, treatment, or condition.
- We were advised of procedures put in place to support a patient who had particular difficulties and anxieties relating to men. The procedure was planned so that minimal male staff were on duty during the hospital attendance. Psychological support was provided and staff were discreetly and confidentially briefed on the patient's background to ensure they were given appropriate support during their stay.
- We observed that staff had time to provide a caring and compassionate service. There were several occasions when staff were observed chatting, re-assuring and spending time with patients.
- We were provided with an example of managing a distressed patient. We were told that a distressed and aggressive patient had been admitted to the ward. Staff spent time with the patient and established their aggression was due to a fear of surgery and the procedure they were due to have. Staff used techniques to defuse the situation, calmed and re-assured the patient in preparation for the procedure.
- Nursing staff could provide emotional support to patients receiving bad news and psychiatric support was available for patients receiving cosmetic, bariatric or breast cancer treatment.

Are surgery services responsive?

Outstanding ☆

Service planning and delivery to meet the needs of local people

- The hospital maintained collaborative relationships with local healthcare partners. 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.
- There had been major investments since 2014 including new MRI and CT equipment, spinal navigation equipment, orthopaedic stacks, a new operating table, patient telemetry, and large bone power tools. Gym facilities were available free of charge for three months post-surgery for orthopaedic, spinal surgery and gynaecology patients.
- The hospital received referrals predominately from regional clinical commissioning groups and the local NHS trust. New surgical opportunities and ventures were discussed with local trusts. During service planning, feedback was sought from the hospital surgical department, finance, and outpatients to establish staffing needs and to formulate the process as well as create standard operational practices.
- There were effective arrangements in place for planning and booking of surgical activity including waiting list initiatives through contractual agreements with the clinical commissioning groups.
- There was good access to the wards. There were lifts available and ample space for wheelchairs or walking aids in each area. We found that the facilities and premises were appropriate for the services that were planned and delivered.
- The hospital offered a lifetime guaranteed price promise for private patients. Any additional care or return to hospital or theatre as a result of surgery received at the hospital was free.
- The urgent transfer of patients who required a higher level of care at the local NHS trust was managed well via longstanding customary arrangements; discussions were ongoing to establish a service level agreement.

Access and flow

- There were 7,843 inpatient and day case episodes of care recorded at the hospital in the reporting period (October 2015 to September 2016); of these 63% were NHS funded and 37% were other funded (insured or

self-pay). Arthroscopy of the knee, knee replacement, and hip replacement procedures accounted for the largest number of surgical procedures performed in the same reporting period.

- Any issues concerning discharge planning or other patient needs were discussed at pre-assessment and documented.
- The provider met the indicator of 94% of patients beginning treatment within 18 weeks of referral for each month in the reporting period, except in October 2015. There was no back log waiting list for endoscopy patients or interventional radiology. Patients were seen within three weeks of their referral.
- Nuffield Health Leeds reported 43 cancelled procedures for non-clinical reasons in the last 12 months; of these 79% (34 patients) were offered another appointment within 28 days of the cancelled appointment.
- There were19 cases of unplanned transfer of an inpatient to another hospital in the reporting period. The rate of unplanned transfers (per 100 inpatient discharges) had fallen over the same period.
- There were eight cases of unplanned readmissions of inpatients to other hospitals in the reporting period October 2015 and September 2016. The rate of unplanned readmissions (per 100 inpatient discharges) had fallen in the same reporting period.
- Nuffield Health Leeds Hospital rarely dealt with unplanned surgery, such as an unexpected return to theatre. 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 to receive emergency patients.

Meeting people's individual needs

- Staff personalised patient care in line with patient preferences, individual and cultural needs. There was no religious support on-site; however, if patients wanted a visit with a religious or spiritual representative during their stay, staff arranged this with external sources.
- Interpreting services were available for patients whose first language was not English. There was access to British Sign Language translation. Leaflets were available for patients regarding their surgical procedure, pain relief, and anaesthetic. All were written in English; however, alternative languages and formats were available on request.
- The hospital had a dementia strategy in place to aid the support of dementia patients and a dementia champion who provided advice and support for staff and patients. All staff were trained in dementia care. The dementia champion attended meetings with other local providers to improve dementia care delivery.
- Patients with dementia or learning disabilities were able to have their carer or family member accompany them to theatre and be there when they woke up. Staff also used the 'This is me' communication tool for patients with learning difficulties.
- There was a single room adapted for dementia patients on the ward. The room had appropriate signage, a red toilet seat, laminated floor, a large clock, and appropriate books. The room was located next to the nurses station. We were advised that adapted cutlery was also available, if required.
- The hospital participated in the NHS safety thermometer and patient led assessments of the care environment (PLACE). PLACE scores showed dementia care scores of 71% between October 2015 and September 2016.
- Staff talked us through the actions taken if a patient became delirious or confused during their admission. It was explained that staff numbers would be increased as necessary and on occasion, one to one support provided.
- The catheter passport was implemented at the hospital in response to identification of a gap in information available to patients who remained catheterised at the time of discharge. This was to ensure continuity of care either by the patient or by a community healthcare provider and reduce the risks of catheterisation. The passport was recognised by all healthcare providers in the locality.
- We saw that patient received 'going home packs'. These packs contained information relating to the type of anaesthetic and surgery the patient received. This

included VTE information, information booklets on their post-surgery care and the National Joint Registry (NJR) consent form for patients happy to contribute to the national database.

- We were told that the hospital provided a private car service designed to assist self-pay or insured patients access the city centre hospital site. From initial consultation through to the first follow-up appointment, patients could be picked up and dropped off at the hospital as part of their package.
- Patients were supported to manage their own health, care and wellbeing and to maximise their independence. Recovery Plus was a recovery programme available free of charge to private and orthopaedic patients at the hospital. The programme provided patients with a personal recovery programme, health check, and exercise and diet advice, together with a three month membership at a Nuffield Health Fitness and Wellbeing Gym.
- The pre-assessment process included a full health assessment. During this assessment, staff were able to identify patients who were at risk of developing diabetes or cardiac conditions. We were told of patients diagnosed with conditions they were unaware of as an outcome of the health assessment. Patients were then provided with an overall health report to discuss with their GP.

Learning from complaints and concerns

- The hospital director took overall responsibility for the management of complaints in line with the Nuffield Health complaints policy. When complaints involved any aspect of clinical care the matron led on the investigation ensuring the relevant head of department was fully involved so that the investigation became a 'lessons learnt' experience for everyone involved.
- Staff told us that they managed patient complaints at the earliest opportunity to resolve issues where possible. Staff were encouraged to make their first response an apology to the patient, to record the details, or to contact a more senior member of staff.
- When a complaint involved a consultant with practising privileges, the process was followed to address concerns with the consultant and involved the medical advisory committee chairman if necessary.
- The hospital provided a 'How to make a comment or formal complaint' booklet to assist patients to provide feedback. There was opportunity to provide feedback via the patient satisfaction survey questionnaire, hospital website enquiry or complaint form, in writing and verbally. Information on how to make a comment or formal complaint was displayed at various locations across the hospital.
- The monthly patient satisfaction survey was discussed at clinical governance committee meetings and heads of department shared comments and scores with their departments.
- Complaints were discussed at senior management team meetings on a weekly basis. Information was cascaded through a number of forums including monthly at the clinical heads of department meeting and clinical governance committee and quarterly at medical advisory committee meetings. Additionally, the heads of departments fed back outcomes and lessons learned at their own monthly department meetings.
- The hospital surgical department received 16 complaints between October 2015 and September 2016.We reviewed five complaint files. All letters of complaint were acknowledged on the day of receipt, the response date was met in all cases, and apologies were provided. Where complaints highlighted learning outcomes for staff, these were discussed on a one-to-one basis and at the monthly team meeting. We were informed that all the complainants reported being satisfied with the response when followed-up by management.
- We saw examples of changes made following patient feedback and complaints; for example, a silent call bell system was implemented following complaints of noise at night.

Are surgery services well-led?

Outstanding ☆

Leadership and culture of 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.
- Discussions with staff highlighted that the overall culture promoted learning and development with continuous improvement in clinical care. Managers accessed courses run by the Nuffield Academy including coaching, leadership skills, and managing 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 they were involved with clinical governance issues. Consultants we spoke with regarded the hospital director and matron as effective and approachable.
- Leaders ensured that employees involved in the performance of invasive procedures were given adequate time and support to be educated in good safety practice, to train together as teams and to understand the human factors that underpin the delivery of safer patient care.
- Many staff highlighted that relationships with senior managers were strong and well established. Staff on the wards said that managers at all levels were visible and assisted on the ward, for example, answering a call bell, chatting with patients and ensuring any problems were resolved.
- Staff we spoke with stated they were respected and valued. There was no current staff reward scheme but we were advised that this was being introduced in the near future.
- We were told by staff that the hospital worked hard to ensure the safety of patients and that clinical practice was monitored closely. We found the culture encouraged candour, openness, and honesty. Staff and teams worked collaboratively, appeared to resolve problems quickly and shared responsibility to deliver good quality care.
- Behaviour and performance inconsistent with the vision and values of the organisation was dealt with through appraisal. However, when necessary, issues were addressed on a one-to-one basis. Staff stated they would be confident to raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes if they ever encountered them.
- Staff felt that their safety and wellbeing was important to the organisation. Staff explained that they were given access to Nuffield Health gyms as a way of promoting physical wellbeing.
- We saw systems in place to ensure people using the service were provided with a statement that included terms and conditions of the services being provided, and the amount and method of payment of fees.

Vision and strategy for this this core service

- We met with senior managers who had a clear vision for the service. The corporate value framework had recently changed and was being disseminated to staff. Some staff were able to explain the new values of Connected, Aspirational, Responsive and Ethical (CARE). Staff were able to explain the previous values of Enterprising, Passion, Independent and Care (EPIC).
- We saw a strategy for achieving the corporate priorities to achieve and deliver good quality care. Staff understood the strategy and their role in achieving it.
- The corporate strategy was to “help individuals to achieve, maintain, and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner”. As a not for profit organisation, their strategy was to fulfil their charitable purpose which was “to

advance, promote and maintain health and healthcare of all descriptions and to prevent, relieve and cure sickness and ill health of any kind, all for the public benefit".

- The local vision was to become the private hospital of choice in Leeds, by ensuring high quality care that was safe, effective, and personalised to the individual needs. The hospital worked in partnership with local NHS trusts and management told us they embraced the role they played, in contributing to the wider NHS healthcare network within Leeds and surrounding areas.

Governance, risk management, and quality measurement

- There was a clear governance structure in place. The Clinical Governance Committee met quarterly and discussed information from reporting groups including infection prevention, medicines management, resuscitation, blood transfusion, complaints and information governance. The committee also discussed incidents, patient safety trends and the risk register. The Clinical Governance Committee was attended by all heads of departments and chaired by the Matron. There was no clinical governance lead consultant in attendance in 2016 as the previous consultant clinical governance lead had retired; however there was close communication with the Medical Advisory Committee. The terms of reference for the Clinical Governance Committee were under review to reinstate consultant involvement.
- The Matron prepared a detailed quarterly clinical governance report which was reviewed by the consultant clinical governance lead and signed off by the hospital director.
- The Clinical Governance Committee reported to the Hospital Board, which reviewed all areas of integrated governance. The Hospital Board received an updated clinical governance report of incidents, complaints and clinical performance indicators at each meeting.
- There were 321 consultants registered with Nuffield Health Leeds Hospital. All consultants awarded practising privileges agreed to abide by the practising privileges policy and provided the organisation with standard information showing they fulfilled the criteria. The register of consultants was reviewed weekly to ensure all documentation was received and up-to-date. We saw evidence of letters to consultants when submission of documentation was delayed and a proactive approach to giving notice of privileges suspension, if required.
- There were five consultants who undertook private practice only and were appraised by a trained medical appraiser employed by Nuffield Health. There was also a corporate revalidation lead for independent consultants. The hospital provided consultants with information about their performance and activity to inform the local NHS medical appraiser in line with national guidance on appraisal for doctors. The appraisal outcome was then shared with the hospital.
- Medical advisory committee minutes were comprehensive and discussed practising privileges, consultant biennial reviews, new policies, clinical governance issues including incidents, complaints, cancelled surgeries, transferred patients, returns to theatre and re-admissions to hospital. The roles and responsibilities of the committee were set out and available.
- There were assurance systems and service performance measures in place to monitor hospital performance. Nuffield Health Leeds Hospital dashboards between October 2015 and September 2016 showed the hospital was performing within expected targets.
- We reviewed minutes for all the clinical governance groups and sub-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, and 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. There was alignment between the recorded risks and what people said was on their 'worry list'.

Public and staff engagement

- There were high levels of staff satisfaction across all groups. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.

- Staff felt actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. It was stated by staff members that when concerns were raised, senior managers took appropriate action.
- Staff engagement took place regularly with the 'Leadership MOT', a survey that goes out to staff for feedback and evaluation of managers. The outcomes were consistently positive.
- Staff had access to the 'In the Loop' staff bulletin, which provided updates on developments and changes. Emails regarding management changes were circulated as necessary and there was a monthly magazine and newsletter specifically about Nuffield Health Leeds Hospital.
- We were advised that staff attended a forum on a monthly basis with additional monthly engagement meetings held on the ward, which were minuted. Staff said they were actively involved in planning care and treatment, including healthcare assistants.
- Staff stated they felt encouraged, supported and helped with professional revalidation. Staff had access to study days and were encouraged to develop their skills.
- Customer Focus groups were held by the hospital to enable patients to share their experiences. We viewed the minutes of a Customer Focus group where patients had expressed their views and opinions of their healthcare experience. Staff described the importance of these meetings and the opportunity to improve patients' experience.
- People who used services were actively engaged and involved in decision-making around their own care and treatment. All patients said they were encouraged to be involved in their care planning and recovery.

Innovation, improvement, and sustainability

- Nuffield Health Leeds Hospital was the first independent hospital in the country to undertake Navigational Spinal Infusion. The equipment delivered real-time guidance of the positioning of instruments and implants along with the ability to correct potential implant misplacement during surgery. It provided surgeons and patients with a significantly greater degree of surgical accuracy.
- 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.
- The hospital utilised professional development resources to improve education and patient safety; for example related to diabetes management, catheterisation, medicines management and quality of documentation. Further education at national vocational qualification and degree level was encouraged and taken up by staff members.
- The hospital maintained strong relationships with local healthcare partners resulting in active roles in areas such as antimicrobial stewardship, infection prevention, professional development and education.
- The hospital employed a full-time coder to support accurate and timely data submission to the Private Healthcare Information Network.

Good

Critical care

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

Are critical care services safe?

Good

Incidents

- There were no never events reported in critical care between October 2015 and December 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Staff informed us that they were aware of the need to report incidents and were encouraged to do so by senior staff. An electronic system was used for the incident reporting and staff told us they received feedback on the outcomes.
- There were 108 incidents reported in critical care between October 2015 and December 2016. Most of the incidents were reported as low or no harm; only one was reported as moderate harm. Staff also reported incidents for near misses and cancelled procedures. We saw that the incidents were investigated, actions taken and each incident with lessons learnt were discussed at the staff team meetings.
- Training was provided to use the electronic reporting system and compliance was at 71%. Four staff were scheduled to complete the training.
- Staff we spoke with understood the principles of duty of candour and the importance of being open and honest with patients. One staff member gave us an example of when duty of candour was applied to an incident, which included an open and honest discussion with the patient and family. Staff told us that this was followed up with a formal letter to the patient.
- Staff told us that in the event of the death of an NHS patient whose procedure was completed at the hospital, consultant surgeons discussed these patients at the local NHS trust's mortality and morbidity meetings.

Clinical Quality Dashboard

- See the Surgery section for main findings.

Cleanliness, infection control and hygiene

- We observed staff using appropriate personal protective equipment when completing clinical tasks. Staff complied with arms bare below the elbows policy, correct hand washing technique and use of sanitising hand gels. Hand hygiene compliance was 83% in critical care in 2016.
- We saw staff cleaning equipment and completing records to identify the cleaning was completed. All the curtains around the bed spaces were disposable, clean and had dates recorded of when they had been changed.
- The unit had infection control link nurses who completed audits and hand hygiene questionnaires for staff. A link nurse attended the hospital infection prevention control meetings and fed updates back to staff. One infection control link nurse advised that they had completed monthly audits to ensure the compliance had increased and fed back the information to the ward sisters.

- We saw that the dirty utility area was clean and tidy. Commodes were available for use and these had stickers on to identify that they had been cleaned. Cleaning equipment was locked away and was accessible for staff to access.
- There were no incidences of Meticillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficilein critical care between October 2015 and September 2016.
- Infection prevention training compliance was 93% and practical assessment was 79% with three staff requiring to complete the assessment.
- The unit recorded the flushing of the water taps daily to prevent legionella. We reviewed the checklists from September 2016 to February 2017 and found all the relevant checks were completed.
- Staff audited compliance with the central venous catheter (CVC) care bundle and the ventilator associated pneumonia (VAP) care bundle. Between July and December 2016, the unit achieved 100% compliance with VAP care bundles and 100% compliance with CVC bundle October to December 2016. The unit had facilities for respiratory isolation.

Environment and equipment

- The unit was spacious and consisted of eight beds spaces, six of these were in a bay environment and two were in single rooms. CCU was a mixed sex area due to the increased level of patient care, however where possible staff tried to cohort same sex patients. At the time of inspection, there were male and female patients on the unit.Staff were aware of theDepartment of Health guidelinesregarding mixed sex accommodation.
- Each bed space had the equipment available for ventilation. Staff completed training for the use of specific machines. We observed staff checking and arranging the equipment in preparation for patients due to arrive on the ward following their surgery.
- A process was in place for repairing faulty equipment and staff were aware of the process to follow. One staff member told us the process they recently followed when they identified a piece of equipment was not working correctly.
- Resuscitation equipment was available on the unit and we saw staff completed daily and weekly checks of the resuscitation equipment.
- We checked sixteen items of equipment including ventilators,intravenous fluidpumps and oxygen equipment. We found them all tohave inventory numbers and validated maintenance dates.

Medicines

- When patients arrived on the unit following their surgery, a critical care specific prescription sheet was used. This included all medication and intravenous medication and fluids to be given until the day following their procedure. The prescription was pre-populated with specific information such as: medication, dosage, route and frequency and/or the maximum dosage to be given within a 24 hour period. Medical staff would sign and date each medication to be administered.
- We reviewed six prescription charts and found that patient allergies had been recorded appropriately. We found a small number of anomalies on some of the prescription charts such as the dosage had been changed and rewritten over the previous prescribed amount. The pharmacist had identified the anomalies, added further information onto the prescription chart for clarity and escalated prescribing issues as required.
- We saw that when medications were omitted, the reason why was identified on the prescription chart and documented within the patient's daily care plan.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Accurate records were kept and daily balance checks were performed.
- Fridge temperatures were recorded daily and documented. We reviewed the checklists from September 2016 to February 2017 and found all the relevant checks were completed.
- The pharmacy team visited the unit every week day and an on-call service was available out of hours and weekends.

Records

- The unit used specific nursing documentation for when patients were on the critical care unit, this identified the patients' level of care and classification. The booklet allowed for information to be inputted for three days

post operatively and continuation sheets were available if required. The documentation included risk assessments and assessments regarding the patients ongoing condition. A physiotherapy assessment sheet was included within the document for completion.

- Each patient also had a daily observational sheet at the end of the bed where observations and daily plans could be recorded. Observations were recorded appropriately and consistently, including sedation scores and ventilator observations. We saw that some medical staff would document on the daily sheet regarding the patient's ongoing care and requirements they needed for the day.
- We reviewed seven nursing records and observational sheets and found that they were accurate and completed correctly in line with the hospital and professional standards. Risk assessments were completed daily and recalculated.
- We reviewed seven sets of medical records. Patients were seen by the consultant surgeon and anaesthetist daily and the resident medical officer (RMO) reviewed the patient at least twice a day. In some records, we noted that the RMO documented that the patient had been seen by the medical team. We saw in three records that the consultant surgeon and anaesthetist completed their own records and recorded on the patient's daily care plan.
- Staff completed training in health record keeping and information governance. The health record-keeping compliance was 93% and information governance was 79%, with three staff requiring to complete the training.

Safeguarding

- See the Surgery section for main findings.
- Staff were aware of how to raise safeguarding concerns for both adults and children, however no safeguarding concerns had been raised in the reporting period. We saw safeguarding flowcharts on the wall to identify the process to follow and staff knew who the safeguarding leads were in the hospital.
- Staff on the unit completed safeguarding training for adults and children. The safeguarding children and young people level two compliance was 86% and rated green for the unit. Safeguarding vulnerable adults compliance was 71% and it was identified that four staff were required to complete the training.

Mandatory training

- See the Surgery section for main findings.
- Information provided by the hospital showed that the unit had an overall training compliance of 71% in December 2016.
- Bank staff were aware that they had to adhere to mandatory training and completed eLearning training. The eLearning system and ward manager would inform them if the training was due for renewal. Bank staff were aware that they would not receive any bank shifts if their training was not up to date.

Assessing and responding to patient risk

- The unit provided care for patients interchangeably between level one, two and three. Specific criteria was met for level three patients and the hospital would link with the local acute trust if any level three patients required to be transferred.
- The unit used the national early warning system (NEWS) assessment tool toassess the patient's condition and identify whenthe patient's condition may be deteriorating.
- All clinical staff were required to complete sepsis training. A sepsis screening tool was in use and staff were aware of the criteria that would indicate when the sepsis screening tool needed to be completed.
- Staff completed delirium scoring on patients and documented this within the record.
- Medical staff could request patients to be admitted for close observation from other departments. For example, being admitted to the unit following a potential anaphylactic reaction to be monitored.
- Staff on the unit provided an outreach service to the wards to support staff if a patient's condition deteriorated. Ward staff could refer to the unit if they wanted a patient to be reviewed and the senior nurse in

charge would complete the assessment. No information was collected to identify the reason why the outreach team was requested. We were told the demand for the outreach service was low.

- Any level two or above patient that had been on the unit was expected to have an outreach visit on the ward within 24 hours of leaving the unit. However we were told that this did not always happen. We observed the outreach service assessing a patient's condition and recording the results on a specific outreach form. The team discussed the outcome and patient's care with the ward staff. An audit of 13 outreach visits from October to December 2016 was completed; this identified that the completed outreach form was not in 53% (7/13) case notes. Management was aware of this and was working on improving performance.

Nursing staffing

- The unit's establishment was 16 registered nurses; healthcare assistants would be requested dependant on need. At the time of inspection, there was one full-time vacancy and two nursing staff on maternity leave.
- Bank staff were used on a regular basis and flexed to meet the demand of surgical activity. Bank staff were skilled and experienced in critical care nursing and told us that they felt part of the team and completed competency assessments. Agency staff skilled in intensive or critical care were used periodically. A critical care agency nurse checklist had been developed by the team to orientate them to the unit, this included information such as the location of the cardiac arrest alarm.
- We reviewed the nursing rota for November and December 2016 and nurse staffing levels met the Guidelines for the Provision of Intensive Care Services 2015 (GPICS) for both level two and three patients.
- There was a senior nurse on each shift and an appropriate skill mix. New staff to the unit were supernumerary for a period of time; we observed this on the nursing rota.
- Nursing handovers were twice a day and included a comprehensive overview of the patients' condition and care plan.

Medical staffing

- All cardiac patients had their own designated consultant surgeon and cardiac intensivist who were responsible for their care at all times during their time on the unit. The cardiac anaesthetists worked as a group and covered each other when unavailable.
- A cardiac surgical registrar was available on-site overnight following any cardiac surgical procedure. They would provide support to the resident medical officer (RMO) and nursing staff on the unit.
- General patients that were admitted to the unit had their own designated anaesthetist for the duration of the admission. If the patient required Level2 or above care, the anaesthetist responsible would identify an intensivist to provide the care required.
- Two RMOs worked within the wards and critical care at all times and would provide cover for each other. One RMO was allocated to critical care and visited the unit several times a day; they were available over a 24 hour period for a two week period. The RMOs received a handover period prior to the end of their two week period. The agency providing the RMOs ensured there was standby cover to provide an immediate replacement if the RMO was unable to work.
- The RMO provided an on-call service out of hours and told us that they received adequate rest during the night. Nursing staff said they had good support from the RMO and felt the RMO had the necessary skills and experience to support the delivery of care and treatment to patients in the critical care unit. Nursing and medical staff told us they would telephone consultants at home if they required advice.

Emergency awareness and training

- See the Surgery section for main findings.
- We saw that a fire warden was identified for each shift on the unit and this was displayed on the nurse staffing board. Staff were aware of the evacuation protocol and could explain this during the inspection. Fire safety training compliance was 79% with three staff remaining to complete the module.

Good

Critical care

Are critical care services effective?

Requires improvement

Evidence-based care and treatment

- Policies and care pathways were based on National Institute for Health and Care Excellence (NICE) guidance and the Faculty of Intensive Care Medicine (FICM). The critical care documentation was based on guidance from the Intensive Care Society.
- The critical care unit did not contribute to the Intensive Care National Audit and Research Centre (ICNARC) case mix programme. This meant the effectiveness of services could not be compared with national standards.
- The unit participated in the hospital's clinical audit programme where audits were relevant to the service. This included quarterly audit of patient satisfaction, infection control and controlled drugs.
- A sepsis screening tool was in place for staff to follow, this was based on the systemic inflammatory response syndrome criteria (SIRS). Staff were aware of the criteria that would indicate when the sepsis screening tool needed to be completed.
- Following changes in practise at the local NHS trust and based on best national practice, consultants instigated two changes in medicines management in the past two years. One related to the administration of aspirin for cardiac surgery patients and the second changed how staff administered potassium from a bolus dose to infusion.
- The unit followed the national Intensive Care Society Sedation for Patients in ICU guidelines (2014) to manage sedation. Staff also used the Richmond Agitation Sedation Scale to rank agitation and possibility for sedation and the Confusion Assessment Method in the ICU (CAM-ICU) to detect delirium in critical care patients.

Pain relief

- We saw that patients' pain relief was reviewed and we observed analgesia being provided. Pain assessments were reviewed and documented using a visual analogue score.
- We asked patients about their pain control and all the patients identified that their pain had been managed appropriately.
- The unit completed critical care satisfaction survey reports from January to May 2016 and asked the patients how well the unit had managed their pain control. The report identified that all ten patients provided a positive response, with seven identifying that it was managed excellently.
- Any concerns regarding pain control were escalated to the medical and anaesthesia teams.

Nutrition and hydration

- See the Surgery section for main findings.
- We reviewed four fluid balance charts and found them to be fully completed and reviewed to identify further action that may be required.
- A nutritional assessment was in place within the documentation. The rating of the score was reviewed and recorded daily to identify if the patient had a high, medium or low nutritional risk rating. Staff commented that they could refer to a dietician if required.

Patient outcomes

- The Core standards for intensive care units (2013), Standard 4.2 states that "the ICU should participate in a national database for adult critical care". The unit did not submit data to the Intensive Care National Audit and Research Centre (ICNARC), and management recognised this as a gap in compliance with the core standards. The unit completed an annual audit, most recently in January 2017, to review critical care service provision in line with the core standards. This highlighted that the unit did not regularly review the effectiveness of care through local and national audit. Actions for improvement were identified, which included joining ICNARC to benchmark clinical outcomes and requesting data from the local acute trust regarding outcome data. We were told by the hospital that there was a plan to look at this in the future. There was no other critical care unit within Nuffield Health for the unit to benchmark patient outcome performance.

Good

Critical care

- Information was submitted to the Society for Cardiothoracic Surgery; however this was submitted by one consultant surgeon via their local NHS employer to ensure an overview of the surgeon's whole practice in relation to activity.
- The unit completed audits for the ventilator acquired pneumonia care bundle and central venous catheter care bundle. Over a six month period the audits identified there was no incidences of ventilator acquired pneumonia or central venous catheter infection. The unit also completed local and corporate audits for resuscitation and transfer. The audit of outreach activity was limited in demonstrating the effectiveness of the critical care outreach service.

Competent staff

- Information provided by the hospital identified that the appraisal rate was 100% in 2016, no figures were provided for the percentage rate for the year 2016/2017. However staff we spoke to identified that they had received an appraisal.
- The unit had a member of staff who was a critical care education lead. They provided management of the deteriorating patient training to the unit, wards and other Nuffield Health hospitals. Training was also provided by staff on the unit for sepsis management training.
- Experienced staff worked on the unit and provided mentorship for newer members to the team. Staff on the unit had link nurse roles such as infection control. They attended the relevant meetings and would feed back at team meetings.
- New staff completed a preceptorship period and were supernumerary for approximately four to six weeks. Staff were assigned a buddy also and we reviewed preceptorship documentation that identified that induction periods were reviewed.
- Information provided by the unit identified that 56% of staff had a post qualification in critical care which met the national standard. Staff told us they were encouraged to undertake further training and some were waiting to complete the critical care training course.
- We reviewed three staff member's training files and identified that competency assessments had been completed as well self-assessments and reviews. Each file contained the National Competency Framework for Adult Critical Care Nurses.
- The pharmacists had completed training in critical care medicines management.

Multidisciplinary working

- See the Surgery section for main findings.
- We observed a Level 3 patient admitted to the unit from theatre following an operation. There was a verbal handover from the consultant to the RMO and nursing staff. Consultant staff would review patients with the RMO and nursing staff on a daily basis.
- Staff told us there was good communication and teamwork on the unit and with other departments within the multidisciplinary team. A physiotherapist visited the unit daily and would contact the unit for updates from the nurses. The pharmacy service visited the unit every week day and an out-of-hours services was also available.
- Access to a dietician was obtained through the local acute trust.

Access to information

- See the Surgery section for main findings.
- We saw that when patients were transferred to the ward, a discharge summary was written within the documentation as part of the transfer. The critical care RMO was available to discuss with the ward RMO any specific individual patient information.
- The majority of records were paper based and accessible to appropriate staff, the nursing observations were kept at the patient's bedside. Staff could access electronic systems for x-rays, bloods results and ordering blood transfusions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtaining verbal consent and giving an explanation prior to completing a procedure. Patients we spoke with also said that staff asked for consent prior to delivering care.

Good

Critical care

- Staff we spoke with demonstrated an understanding of consent, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- Staff completed consent to examination or treatment training with an overall compliance of 86%. Staff completed DoLs training with an overall compliance of 64% with five staff still required to complete the training. All staff had completed Mental Capacity Act training.

Are critical care services caring?

Good

Compassionate care

- We saw patients were treated with dignity and respect during our inspection by all members of staff. We spoke with seven patients who were all continually positive and identified that the care they received on the unit was excellent. Comments included "could not wish for better" and "the care here is marvellous".
- Staff took time to interact with patients and relatives in a respectful and considerate manner. Staff commented that they had time to be able to care for the patients and could provide them with excellent care.
- Individual care was provided and we were told that staff had previously accommodated patient's wedding anniversaries and been to local shops to buy specific food for patients. During our inspection it was one patient's birthday, staff had arranged for a birthday cake to be made and all staff congratulated the patient on their birthday.
- The unit completed critical care satisfaction survey reports. Ten patients completed the survey; due to the nature of the care on the unit, some patients identified that they could not remember all the care they received on the unit and this accounted for the low response rate.The surveyasked the patients about privacy and dignity. The report identified that nine out of ten patientsfound this to be excellently maintained. The report identified comments that had been made by the patients, these included: "everything was perfect", "nothing you could have done better" and one felt "reassured at every point".
- We saw various thank you cards on the ward from the patients and relatives which contained positive feedback. Some cards identified specific staff for the extra care they provided. We saw in one card which stated, "You were a tower of strength in my weakness. Not only mine but the family too".

Understanding and involvement of patients and those close to them

- We spoke with three relatives who commented that they had all been kept informed. The staff on the unit had contacted them to let them know when the patients arrived on the unit and to update them on their condition. Where patients had required more close observation and further tests, the staff had informed the relatives.
- One relative told us that the nurse asked them their level of understanding and knowledge about the care being given and explained it in a way they understood well. Staff showed creativity to overcome obstacles to deliver care, such as drawing diagrams for patients and relatives to understand certain information.
- We observed patients were involved during their care. During the inspection, one patient required closer observation due to their condition and we saw staff were fully committed to involving the patient and family. All seven patients we spoke with said that they felt involved and participated in their care.
- When required, staff on the ward contacted insurance companies identifying the reason why a patient had stayed in the unit longer than two days.

Emotional support

- During the inspection, we saw the prompt response to a patient who was suffering from nausea, with the nurse responding very quickly and provided medication to alleviate the symptoms.
- Staff were supportive to patients and showed a high level of empathy and compassion on the unit. The staff demonstrated they were aware that patients felt vulnerable and empowered patients to realise their potential. We saw staff putting them at ease and reassuring patients while moving their positionafter surgery. We heard staff offer advice to the patients in how to move their position and praise them on how well they had done.

Good

Critical care

- Patients received pre-operative visits and information from critical care staff to ensure patients were prepared. This helped to reduce anxiety. Patients were also offered the opportunity to visit the unit prior to admission. We were told that some patients accepted the offer and would visit the unit to see where they would be nursed, meet staff and have the opportunity to ask questions.
- The critical care satisfaction survey asked the patients how well the unit had managed their emotional concerns. From January to May 2016, ten patients completed the survey and all provided a positive response, with eight rating this aspect of care as "excellent".

Are critical care services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital had an agreement with clinical commissioning groups to provide specific treatment and care for NHS patients. This included cardiothoracic and spinal surgery.
- The hospital liaised closely with the acute trust if it was identified that patients needed to be transferred. Staff from the unit attended local critical care operational networks with critical care staff from the local NHS hospital staff. The hospital had established an informal agreement with the local NHS trust to accept patients to support their critical care needs. However, a formalised patient transfer arrangement was not in place.
- Cardiac surgery admission criteria were in place. The unit would also accept patients from the ward that consultants required to be closely monitored. Patients with a specific body mass index were also admitted to the unit for their post-surgical care.
- A visitors waiting room was accessible for use; the room was spacious, with seating and drink provisions. We saw that relatives used the waiting room and staff would speak to them prior to seeing the patient. Overnight accommodation was not available on site, however staff said that relatives had stayed over next to the bedside in comfortable seating.

Access and flow

- Most patients were pre-booked into the unit prior to their surgery. The unit would also admit other patients on discussion with their consultants. The unit did not normally have all eight beds occupied at one time and could accommodate unplanned admissions if patients needed a higher level of observation or for an emergency situation. For example one patient was admitted to the unit following a respiratory arrest in surgery, the patient was monitored overnight and returned to the ward.
- There were 2,928 Level 2 critical care bed days available in the hospital between October 2015 and September 2016; 658 Level 2 bed days were used, giving an occupancy rate of 22%.
- There were 2,928 Level 3 critical care bed days available in the hospital between October 2015 and September 2016; 295 Level 3 bed days were used, giving an occupancy rate of 10%.
- The average length of stay on the unit was normally two days. Dependant on the patient's medical condition, the patient could stay on the unit longer for close observation. The unit recorded the length of stay per month.
- The unit monitored delayed discharges, readmissions and unexpected admissions. Between January 2016 and December 2016, three patients were readmitted.
- Patient who were required to be transferred out to the local acute trust were discussed at the resuscitation meetings. We saw in resuscitation minutes that patient cases were discussed to identify if there were any trends or learning from the transfers. From February to December 2016, seven patients were transferred out of the unit.

Meeting people's individual needs

- Staff responded to patient's psychological needs whilst on the unit. The unit felt they were confident to care for patients with a learning disability and had previously requested healthcare assistants to provide extra support for patients. The unit did not normally receive patients living with dementia, however staff had received dementia training and felt confident in caring for these patients.

Good

Critical care

- Translation services were available and staff were aware of how to contact these. Staff told us that specific needs were identified at their pre-assessment appointment. Staff told us that they had used relatives to translate for the patient at times.
- All patients with a higher body mass index would be managed within critical care and bariatric equipment was hired individually for patients if required.
- We saw that patients were provided with options for food including light meals, for patients that did not require a full meal. Staff assisted patients where required and we observed food and drink in reach of patients.

Learning from complaints and concerns

- See the Surgery section for main findings.
- Staff were aware of how to respond to complaints and understood the process. The unit had not received any formal complaints between April 2016 and December 2016. Staff commented that they received very few complaints on the unit.
- Patients we spoke with were aware of how to raise a complaint, but did not need to complain about the service. Information and leaflets were available if they required to make a complaint.

Are critical care services well-led?

Good

Leadership and culture of service

- The Core Standards for Intensive Care Units, (2013) state that care in intensive care units must be led by a consultant in intensive care medicine. A designated lead consultant for critical care was not assigned, as each consultant surgeon and intensivist looked after their own patients. Management recognised this gap and it was recorded in their annual audit against the national Core Standards for Intensive Care (2013). We spoke with the hospital director at the time of our inspection regarding medical leadership on the unit and discussions were ongoing with the local NHS trust critical care unit team about this issue. There was consultant representation from cardiac surgery and anaesthesia on the medical advisory committee.
- The nurse manager was accessible on the unit and provided clinical support and nursing leadership. The matron, who was experienced in critical care, also provided ongoing support on the unit.
- We found that morale on the unit was very positive. Staff told us that candour, openness, and honesty was encouraged.
- Nursing staff told us they felt very supported, valued and enjoyed working on the unit. Staff were highly complimentary about the ward manager, describing them as very supportive and encouraging. The staff also felt supported by the nursing team, RMOs and consultants. Staff told us the culture of the service was focused on meeting the needs of patients and it felt like a 'family' working on the unit.
- We spoke to one nursing student on the unit who felt that they were part of the team and staff regularly sought feedback on the quality of the placement in critical care.

Vision and strategy for this this core service

- See the Surgery section for main findings.
- The unit used the same vision and values as the hospital; these had recently changed and staff were currently being informed of the changes. All staff we asked said the vision for the unit was to provide excellent, individual and compassionate care to patients.
- We observed staff delivering care and demonstrating behaviours in line with the hospital's values.

Governance, risk management and quality measurement

- See the Surgery section for main findings.
- The unit manager attended various hospital governance and operational meetings and cascaded information to staff on the unit at team meetings. We reviewed the last three meeting minutes and identified that there was a

set agenda looking at patient safety, operations, finance, risk management and human resources. We saw that any incidents, transfers out of the unit and learning were discussed.

- One of the consultants supported the resident medical officers and worked with the unit manager to investigate incidents.
- Practising privileges for consultant surgeons, intensivists and anaesthetists were reviewed on an annual basis by the medical advisory committee to ensure they had the relevant skills and experience to carry out their role. The lead anaesthetist and consultant cardiac surgeon attended the hospital's medical advisory committee.
- Staff were familiar with the process for escalating risks. The hospital wide risk register had no specific items that related to critical care. The unit was looking towards developing a local risk register specifically for critical care.
- There was no national benchmarking of patient outcomes and management was considering participating in the Intensive Care National Audit and Research Centre (ICNARC) case mix programme.

However, there was evidence of improvement in clinical practice through aligning with practice at the local NHS trust and dissemination of learning from the local critical care network meetings.

Public and staff engagement

- See the Surgery section for main findings.
- Team meetings were held every two months and minutes were circulated to all staff. Staff told us that they could discuss any issues or concerns at the meetings and were kept informed of potential changes to the unit.

Innovation, improvement and sustainability

- A member of the critical care nursing team attended the local critical care network meetings. This provided opportunities to network and update on critical care services. Information was cascaded to the team and implemented on the unit. This ensured that the hospital was following the same protocol and procedures as the local NHS trusts.
- The critical care team had developed a training programme on the management of a deteriorating patient; they provided this training to hospital ward staff and to staff at other Nuffield Health hospitals.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

Incidents

- No Never Events were reported in children's services between October 2015 and September 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.
- Children's services reported no serious incidents between October 2015 and September 2016.
- Staff we spoke with were aware how to report incidents using the electronic reporting system and had attended training on the use of the electronic reporting system. There had been no reported incidents in children's services within the last year.
- We reviewed paediatric governance meeting minutes and saw that incidents were a standing agenda item to be discussed when these occurred.
- Staff were aware of the duty of candour and spoke about being open and honest with families; there had been no incidents that required the duty to be implemented.

Cleanliness, infection control and hygiene

- All areas of the hospital providing services to children and young people were visibly clean and well maintained.
- Department of Health Guidelines (2013) Health Building Note 00-09: Infection control in the built environment states that "carpets should not be used in areas where body-fluid spillage is anticipated". The hospital build pre-dates the Department of Health guidelines, but managers told us that compliance with the guidelines would be a key factor in any planned refurbishments.
- There was carpet throughout the ward area. This was not on the risk register, but was identified in the Infection Prevention and Control Gap Analysis undertaken in June 2016. The gap analysis identified the need to change flooring in line with best practice and a business case was developed in response. The regional team had approved the business case to replace the carpets by the time of inspection and the case was awaiting corporate approval. Management anticipated the programme for replacement to start in summer 2017. Standard operating procedures were in place and implemented for dealing with spillages.
- Hand gel dispensers were available in the patient rooms, including child friendly hand sanitiser dispensers. Children were encouraged to wash their hands and were given posters to colour in associated with hand washing. Hand hygiene compliance rates for 2016 were 77% in the ward areas. An action plan was in place to improve compliance.
- Staff complied with 'bare below the elbow' policy and we observed them using the hand gel provided. Personal protective equipment was available and used when needed.

Good

Services for children and young people

- Infection prevention training compliance rates were 95%, with practical assessment compliance at 81% for the hospital as a whole.
- We saw completed cleaning records for the toys on the ward and in the outpatient department.

Environment and equipment

- There was a designated ward for children and young people (CYP) situated within the day ward, with a secure entry code to prevent unauthorised access. The children's ward had child friendly decoration and there was a play room for the younger children.
- If any child or young person needed to stay overnight, they were moved to a designated room within the inpatient ward. The inpatient ward could be secured to ensure the safety of the children.
- The ward had single ensuite rooms which allowed for effective isolation of patients if required. Clinical hand washing facilities aid staff to maintain effective hand hygiene between patients and prior to care and treatment. However there was a lack of clinical hand washing facilities in the rooms and on the corridor. Health Building Note 00-09 states that: "ensuite single bedrooms should have a general wash hand basin for personal hygiene in the ensuite facility in addition to the clinical wash hand basin in the patient's room". The hospital was built prior to the introduction of this guidance and managers told us compliance would be a key factor in any planned refurbishments. This gap was identified in the Infection Prevention and Control Gap Analysis in June 2016 and the senior management team planned to install two clinical wash hand basins in the ward corridor during 2017. Staff were washing their hands in the clean utility room at the time of inspection.
- Paediatric resuscitation trolleys were located in the children's ward, outpatients department, radiology department and theatres. We saw completed records to confirm that appropriate checks had taken place, with no gaps in the records.
- After surgery, children were recovered in a designated area which could be screened off from adult patients if required. As theatre lists were held on a Saturday, children were often in the recovery area without adult patients being present.
- Paediatric equipment was available and we saw that appropriate electrical safety checks were completed.

Medicines

- The pharmacists had undertaken training in paediatric medicines management as part of their qualification. The pharmacist visited the ward daily to check prescription sheets and collect any discharge medicine prescriptions to be dispensed. We saw evidence of the pharmacist documenting in the patients record when they had seen them.
- Medication was stored securely in a locked room. We checked the drug cupboard on the ward and found it to be clean and well organised, with all medications in date.
- The drug area temperature was checked daily and we saw records to confirm these checks had been undertaken.
- The ward did not routinely keep controlled drugs and did not have a medication fridge.
- We reviewed 10 prescription charts and found all had a height and weight recorded to allow for proper prescribing of medication. Any allergies were noted. Care records had a section for recording emergency drug and fluid calculations. This would enable staff to access appropriate doses of medication, based on height and weight, if needed in an emergency. Out of 10 records that we reviewed, four did not have this section completed.
- We observed a consultant in clinic giving appropriate evidence based advice regarding the use of antibiotics.

Records

- We reviewed 10 records for children and young people. Records were paper based and all records we reviewed were up to date, accurate and legible.
- Patient records were kept securely in a trolley at the nurses station when children were admitted to the ward for surgery.
- Staff told us they always had access to patients' notes for admissions and outpatient appointments.

Safeguarding

Good

Services for children and young people

- The matron, deputy matron and the lead registered children's nurse were the safeguarding leads for the hospital. All were safeguarding Level 3 trained, as were the Resident Medical Officers.
- A Nuffield Health safeguarding children, young people and adults policy was available. This was issued in April 2016, reflected the latest national safeguarding training guidance and was due for review in April 2019. We saw a flow chart for staff to use when raising any safeguarding concerns and the lead children's nurse was responsible for linking with the local Safeguarding Board contacts.
- Guidance was available for staff regarding child sexual exploitation (CSE) and female genital mutilation (FGM). CSE and FGM were covered in the safeguarding training so staff had an awareness. There was an up-to-date abduction policy and a flow chart for staff to follow, however staff told us that this had never been tested in practice with mock scenarios. We saw on the local risk register that a scenario was planned.
- Staff gave parents or legal guardians red wrist bands to wear on the ward so that they were easily identifiable and this helped staff to be aware of any other adults that may have accessed the ward that should not be there.
- There had been no reported safeguarding concerns in the last 12 months but staff we spoke with were able to tell us how they would recognise and respond to concerns.
- When we spoke with staff, some were unclear as to what level of child safeguarding training they had received. We also found that the central training database did not fully reflect all the staff members who had received safeguarding children Level 2 training. Where the training profile was amended locally to include Level 2 to meet the needs of the local paediatric service, attendance was not automatically recorded on the central system. The corporate training database has since been adjusted to ensure that the training data reports fully reflect compliance levels in all relevant modules including those modules added to training profiles locally.
- We found that staff training complied with the intercollegiate document 'Safeguarding children and young people: roles and competencies for health care staff' (2014), which says that "Level 2 training should be attended by all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers."

Mandatory training

- Mandatory training included incident reporting, fire safety, health, safety and welfare, managing stress; whistleblowing, infection prevention, basic life support, safeguarding children and young adults Level 1, safeguarding adults Level 1 and information governance.
- The data provided did not break down the training for the children's service specifically. However, hospital wide they were meeting the target of 85% compliance for most of their mandatory training. Incident reporting (87%), fire safety (91%), health, safety and welfare (93%), managing stress (87%), whistleblowing (98%), infection prevention (95%), basic life support (78%) and information governance (89%).

Assessing and responding to patient risk

- The hospital had strict admission criteria: no children under the age of three were admitted for surgery, children with additional pre-existing conditions would not be admitted for surgery and the hospital did not carry out emergency surgery.
- Readmissions were only accepted when all the resources required were available.
- The hospital had a service level agreement with an external paediatric retrieval service for children that needed transfer to an NHS hospital for urgent critical care. However, staff told us that they had never had to transfer patients.
- A Paediatric Early Warning Score (PEWS) tool was in use. A PEWS tool assists medical and nursing staff in the prompt detection of any deterioration in a child's condition to ensure the child receives appropriate care at the earliest opportunity. Out of 10 records that we reviewed, two did not have the PEWS score calculated with every set of observations; however the observations were within normal limits.

- A surgical safety checklist, used to ensure the safety of patients undergoing surgery, was in use. We saw appropriately completed checklists in the 10 records we reviewed. We observed a safety checklist carried out appropriately in the anaesthetic room.
- All children and young people admitted for surgery had a pre-admission assessment undertaken by one of the registered children's nurses. This was offered face-to-face but could be done over the telephone if required.
- We observed a pre-assessment appointment which included confirming the child's medical history, providing information about the surgery and aftercare. Parents were also provided with information about sepsis.
- Environmental assessments were done when the child was admitted. Checks were carried out for bed height, window/door opening, scalds and burns, water temperature, ingestion, sharps injuries, toys, room appearance and availability of hospital information pack.
- We observed a bed management meeting and heard that planned admissions involving children were discussed to ensure that the appropriate clinical resources were in place for the admission.
- Paediatric simulations of emergency situations were carried out. Staff told us that the last one was a simulation of a child suffering an anaphylactic reaction in the outpatient department in December 2015.

Nursing staffing

- The hospital employed two permanent, dual registered, children's nurses. When children were admitted for surgery, two registered children's nurses were on duty and this would normally be one permanent member of staff and one bank registered children's nurse. This ensured that staffing complied with the Royal College of Nursing (RCN) standards 'Defining staffing levels for children and young people's services' (2013) which recommend a minimum of two registered children's nurses. Regular bank staff were used and approved agency children's nurses were used if necessary.
- One permanent member of staff was on call, so that if a child unexpectedly needed to stay overnight after surgery there would be a registered children's nurse to care for them.
- Staff told us surgery would be cancelled if the required specialist staff were not available. However, they said this situation had not arisen and data showed there had been no cancellations in the last year.
- The registered children's nurse was present in the outpatients department for any invasive procedures for children. For routine outpatient clinics, the children's nurse would not be present in the department but was available in the hospital if needed.
- We observed one of the children's nurses attending clinic when they were notified that a child was to have blood tests done.
- Children were looked after in theatre recovery by two nurses. RCN standards (2013) recommend that at all times there should be a minimum of one registered children's nurse on duty in recovery areas. Although the nurses in theatre recovery were not registered children's nurses, they had experience of looking after children and were paediatric immediate life support (PILS) trained. They could access the registered children's nurse for advice and support.

Medical staffing

- There were three consultant paediatricians with practising privileges at the hospital. They were accessible to other consultants for referral, advice, support or opinion. All of these consultants had substantive posts in NHS trusts.
- The hospital had processes in place to ensure consultants had the appropriate skills and experience to care for children and young people. The medical advisory committee (MAC), paediatric governance committee and the senior management team monitored paediatric practice and medical revalidation.
- The designated lead paediatrician and the lead paediatric anaesthetist attended the paediatric governance meetings; the lead paediatrician also attended the MAC meetings.

Good

Services for children and young people

- There were two resident medical officers in the hospital at any one time. They were available 24 hours a day, seven days a week and were trained in advanced paediatric life support (APLS).

Emergency awareness and training

- See the Surgery section for main findings.

Are services for children and young people effective?

Not sufficient evidence to rate

We have not rated effective due to insufficient evidence.

Evidence-based care and treatment

- Staff had access to policies, guidelines and standard operating procedures (SOP) on the intranet and hard copies kept in a folder on the ward.
- We reviewed 11 policies and SOPs, including bookings, pre-op assessment and discharge following treatment/ surgery. All were in date and were clearly evidence based.
- We saw that the fasting guidelines were based on national guidance produced by the RCN.
- Paediatric governance meeting minutes contained evidence of discussion of national guidance such as intravenous fluid therapy in children and young people in hospital from the National Institute for Health and Care Excellence (NICE).
- Audits were completed to ensure compliance with corporate policies, such as documentation audits. The data provided for documentation audits was not broken down specifically for children's services.

Pain relief

- Child friendly pain charts were embedded in the paediatric early warning score charts which were based on the Wong-Baker FACES pain rating scale. The scale shows a series of faces ranging from a happy face at 0, "No hurt" to a crying face at 10 "Hurts worst". These can be used with children three years and older to improve assessment and management of pain.
- In the records we reviewed, we saw that pain assessments had been recorded.
- We spoke with three parents about their child's pain management whilst they were in hospital. All three said their child's pain had been well managed.
- One parent of a seven year old told us that their child's pain had been well managed by theatre recovery staff and had been assessed using the smiley face pain tool.
- We observed a child in theatre recovery being asked about their pain and the surgeon checking on them before he started the procedure on his next patient.

Nutrition and hydration

- Children and parents were given information about appropriate fasting times during the pre-assessment and children's dietary requirements and allergies were assessed on admission.
- Drinks were available at all times, when not fasting, for the children and parents and parents were able to choose from the menu and eat with their children.

Patient outcomes

- Children and young people services did not participate in submitting data to national audits.
- An under-five's tonsillectomy audit was done in October 2016 in response to the new tonsillectomy guidelines from the national Ear, Nose and Throat (ENT) specialist association, ENT UK. The guidelines suggested that children under 15kg were not suitable for tonsillectomy. The audit benchmarked clinical practice prior to the new guidelines being issued and it found one out of seven children operated on was under 15kg and had received a tonsillectomy. The action taken included discussing the audit outcome and new guidelines at the paediatric governance committee, communicating the guideline to the paediatric ENT surgeons and the requirement that all children were weighed at pre-assessment and any under 15kg did not proceed with a tonsillectomy.
- There were no unplanned transfers to the local NHS trust and no returns to theatre in the reporting period.

Competent staff

Good

Services for children and young people

- Registered children's nurses cared for children admitted to the hospital for surgery. The lead children's nurse attended the Nuffield Health children and young people forum in order to keep up to date with new developments.
- Bank staff were offered shadow shifts before they started to enable them to familiarise themselves with the hospital and its policies. Online training could be accessed at home.
- Staff in the outpatients department told us that the lead children's nurse would keep them up to date with current practice and any issues concerning children and young people.
- The RCN document, Defining Staffing for children and young people's services: RCN standards for clinical professionals and service managers (2013) recommend that "at least one nurse per shift in each clinical area (ward/department) will be trained in advanced paediatric life support depending on the service need". None of the nursing staff had completed this training but had completed paediatric immediate life support (PILS) training. An anaesthetist with APLS training was present in theatres for every surgical procedure on children and monitored their recovery until transfer to the ward.
- The corporate policy for paediatric basic life support (PBLS) training policy changed in 2016 and increased the target group to healthcare assistants, radiographers and physiotherapists. We were told that the planned target for compliance for PBLS was 90% by 31 March 2017.At the time of inspection, compliance was 50% for the relevant staff and additional courses were scheduled.
- Similarly, the target group for paediatric intermediate life support (PILS) had also been extended and compliance was 36% for relevant staff at the time of inspection. Additional courses were scheduled and the hospital planned to reach 75% compliance by 31 March 2017.
- We saw a children and young people's register, which had the names and speciality of consultants with practising privileges for children and young people. Included were resuscitation and safeguarding training information and evidence of activity for working with children and young people.
- Children who required physiotherapy were seen by a physiotherapist who had paediatric experience.

Multidisciplinary working

- Staff told us there was good communication between the different services in the hospital. We observed a physiotherapist visiting the ward to see patients post orthopaedic surgery and the pharmacist coming to check prescription charts. Both liaised with the nursing and medical staff about the plan of care.
- The paediatric governance meetings were multidisciplinary and attended by a paediatrician, an anaesthetist, nursing staff from the ward, outpatients and theatres, matron, deputy matron and the clinical governance co-ordinator.
- We observed good collaboration between theatre and ward staff. Handovers were based on SBAR (Situation, Background, Assessment and Recommendation). SBAR is an effective and efficient way to communicate important information.

Access to information

- There was a single set of fully integrated paper records for all patients with the exception of physiotherapy patient records, which were held on an electronic system. All the information needed for paediatric care was easily accessible.
- Staff had access to policies and guidelines on the intranet.
- Discharge letters were faxed to GPs to inform them of the child's admission. Letters were also given to patients to take to school with any special instructions following surgery.

Consent

- There was a corporate policy available for staff 'Consent for examination or treatment' that was dated August 2015. This contained comprehensive guidance specific to managing the consent of children that included information to guide staff if a parent was unable to give consent due to lack of mental capacity.
- The care record contained a section that identified whether the child or young person understood the reason for their admission.

Good

Services for children and young people

- Staff we spoke with understood Gillick competency but we saw no evidence of documentation to support that Gillick assessments had been done. Gillick competence is the principle used to judge capacity in children to consent to medical treatment.
- We saw consent forms signed by parents in the records we reviewed, but we did not see any that had been signed by the children. We saw three records for children who were 14 years old who potentially could have given consent.

Are services for children and young people caring?

Outstanding ☆

Compassionate care

- Feedback from patients and their parents/carers was continually positive about the way staff treated them. They felt they received care above their expectations and would return to the hospital.
- We spoke with eight parents and three young people. The children, young people and parents we spoke with told us that the care they had received was excellent. The nurses were described as "wonderful", "lovely" and "amazing" with some describing them as "going above and beyond" and "nothing was too much trouble".
- Parents we spoke with described all staff, including catering staff, porters and car parking staff as professional. There was a visible person-centred culture. Staff recognised and respected the children's needs.
- We saw staff acting in a friendly and compassionate manner to children and their families. Staff maintained privacy and dignity by knocking on doors before entering.
- Parents told us that they felt their child was safe and well looked after. Two of the children had been to the hospital more than once and the parents described the care as consistently good, with one saying they had one word to describe it, which was "outstanding".
- We saw staff in other departments, such as radiology, treating the children with kindness and compassion.
- There were no Friends and Family Test (FFT) data specific to children's services, but overall results showed that 99.3% of patients would recommend the service they received from April to December 2016.
- We saw complimentary letters from parents that had been written to the lead children's nurse.
- All children and young people were offered a Nuffield Health Leeds Hospital bag to take home which contained a water bottle, pen and teddy bear.
- We spoke to one parent whose child had an attachment disorder; they told us that the staff had been wonderful and they would definitely return to the hospital for any future care.

Understanding and involvement of patients and those close to them

- Children, young people and parents we spoke with told us they were kept fully informed and involved in decisions about their care. We saw children and young people spoken to in a way they could understand.
- We observed an admission for surgery and full explanations were given to the young person as to what would take place, including how they would feel once the anaesthetic was administered. The young person was given the opportunity to ask any questions.
- Children were involved in all the planning and discussions throughout. Pictures, x-rays and diagrams were used to explain procedures to the children.
- We observed a radiographer explaining the process of an x-ray to the child in an age appropriate manner, using a doll to help explain the procedure.

Emotional support

- We observed the theatre recovery nurses coming to the ward to introduce themselves to the children, young people and families so that the children and young people would see a face that they recognised in recovery.
- We saw support being provided to a parent that had a needle phobia. It had been discussed at the pre-admission assessment and agreed with the child that the nursing staff would support the child in the anaesthetic room without the parent present.

Good

Services for children and young people

- Parents were able to accompany their children to the anaesthetic room; the children's nurses supported children and their parents.
- Young people and their parents told us that the staff continually kept them updated which helped ease their anxiety.
- We observed a paediatrician in clinic making time for the parents, showing empathy and compassion and asking them how they were feeling.

Are services for children and young people responsive?

Good

Service planning and delivery to meet the needs of local people

- Children and young people were nursed in a completely separate area from adult patients in a ward area that was secure and suitable for children and young people.
- Children and young people were nursed in individual rooms and to give young people more privacy, the staff allocated them rooms at the end of the ward. Young people could access the hospital Wi-Fi to keep in touch with friends on social media. Staff had started to provide information to the young people about internet safety.
- Surgery for children and young people had recently been reviewed and all paediatric lists had been brought together to be held on a Saturday, rather than as required, to ensure that appropriate specialist staffing was available.
- The outpatients department had a consulting room that was used for the paediatric clinics which had child friendly decoration and a number of toys.

Access and flow

- All surgical procedures were planned and there were no problems with bed availability. At the time of our inspection, there were two theatre lists a month and each list had an average of four patients. Staff told us there were no waiting times for admission and treatment. We spoke with a paediatric surgeon who told us he arranged his lists to accommodate the needs of the children and families.
- A dedicated paediatric theatre list ensured that children were not waiting too long for their surgery. Surgery took place in the morning to allow for recovery time and discharge home the same day. It also meant that all the necessary clinical resources were in place and this ensured that surgery lists were completed safely.
- A booking process was in place to ensure that children and young people were not booked for surgery or seen in clinic without appropriately trained staff being available. We spoke with two parents in the outpatient department and they told us that the booking process had been straightforward and simple. One family had travelled a long way for their child to be seen at the hospital because the paediatrician was a specialist in respiratory care.
- Physiotherapists with paediatric experience saw children aged five years to 18 years referred with musculoskeletal problems.

Meeting people's individual needs

- All children and young people admitted for surgery were low risk and did not have complex needs. However, staff told us they did sometimes admit children with mild learning disabilities. In these cases, the staff worked with the parents to determine what would be best for the child. For example, one child did not come in to hospital for the pre-operative assessment as the parents felt it would make them more anxious.
- Staff had access to face-to-face interpreter services if needed for families that did not speak English. They could also access British Sign Language translators if required.
- All rooms had a television with DVD player and access to books and toys. Children were able to bring with them their own electronic devices. There was a small designated children's waiting area in the outpatients department with a selection of toys.
- The lead nurse had devised a folder and a leaflet that had pictures to explain different procedures and the journey to the operating theatre for younger children.
- Parents were given contact numbers for the ward to ring if they needed advice following discharge. Nursing staff that took the calls would contact the registered children's nurse if necessary.

Good

Services for children and young people

- A specific children's menu was available which offered a good variety of healthy nutritious meals. The hospital catered for special diets such as halal and gluten free.

Learning from complaints and concerns

- See the Surgery section for main findings.
- There had been no formal complaints received about the children's service within the last 12 months.
- We saw leaflets available on the ward and in the outpatients department, informing patients and family members how to make a complaint if they needed to.
- Staff we spoke with told us they contacted parents by phone after discharge from hospital and this enabled a discussion to take place around any concerns they may have.
- Parents we spoke with told us they knew how to make a complaint. They had received a follow up telephone call and had been offered a pack with a leaflet about how to complain.

Are services for children and young people well-led?

Good

Leadership and culture of service

- The lead paediatric nurse and deputy matron (also a paediatric nurse) managed the services for children and young people. We spoke with a bank member of staff who described the lead children's nurse as "exceptional". They described her as dedicated and very approachable.
- Staff in other departments were aware of the lead children's nurse and said they could approach her at any time for support and advice.
- Staff described an open culture and they felt able to raise any concerns with senior management.
- Staff we spoke with felt that senior management at the hospital supported staff well. One staff member told us they had recently returned from extended sick leave and that the senior managers had been very supportive.

Vision and strategy for this core service

- See the Surgery section for main findings.
- The hospital had a vision to become the 'private hospital of choice in Leeds'. The values were to be Connected, Aspirational, Responsive and Ethical (CARE). Staff we spoke with were aware of the hospital's vision and values.
- There was no documented strategy related to children's services; however we saw evidence of the service being discussed at the paediatric governance and senior management meetings. We saw meeting minutes where discussion took place about increasing the paediatric service and the challenges of recruiting suitably qualified specialist staff.

Governance, risk management and quality measurement

- There was a clear governance structure in place for children and young people's services led by the Matron. Quarterly paediatric governance meetings reported into the hospital clinical governance committee and via the matron into the medical advisory committee (MAC) and hospital board. A lead paediatrician was part of the paediatric governance group and the MAC.
- The paediatric governance meetings and the MAC reviewed best practice, national guidance, NICE guidance, patient feedback, complaints, incidents and lessons learned as well as any safeguarding incidents.
- We reviewed MAC meeting minutes and board meeting minutes and saw evidence of discussion of children and young people's services.
- The hospital risk register had a risk related to the provision of paediatric services. A full review of services had been done in December 2015 and the position continued to be reviewed by the paediatric governance committee.
- During the inspection we saw the children's services local risk register completed in January 2017, which identified potential risks, control measures in place and any further actions needed to reduce the risk. Dates were in place for review.

Public and staff engagement

- The hospital obtained feedback from patients with the use of a patient satisfaction survey. They had recently

developed a children's satisfaction survey, which was given to those children admitted for surgery. Staff in outpatients told us they did not have a survey specific to children in the department.

- Staff told us that there was a patient focus group to engage with the public; however, these were not specific to children and young people.
- Staff forums were held where staff felt able to put their views forwards. The hospital director was new in post and staff said he had made himself known and was approachable.

Innovation, improvement and sustainability

- The lead children's nurse had devised a leaflet for children and young people to guide them through their surgery. She hoped to take this to the corporate children and young people meetings to discuss other Nuffield Health hospitals using the same.
- Staff we spoke with spoke positively about the services for children and young people and were keen to support any improvements. For example, when asked if they provided information about internet safety to children and young people, they did not have anything in place, but identified suitable information that they were then providing to patients before the end of the day.
- The hospital had established a private paediatric scoliosis service as part of the spinal services provided by the hospital.

Outstanding ☆

Outpatients and diagnostic imaging

Safe	Good ●
Effective	
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Good ●

Are outpatients and diagnostic imaging services safe?

Good ●

Incidents

- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff we spoke with had received training and knew how to report incidents using an electronic reporting system.
- Between October 2015 and September 2016, there had been no never events reported for outpatients and diagnostic imaging services. 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 same reporting period, the hospital reported no serious incidents. Serious incidents are incidents that require reporting and further investigation. Between September 2016 and the time of our inspection, there had been one serious incident reported in radiology when an X-ray had been performed on the wrong knee. The incident was reported to the radiation protection advisor (RPA), fully investigated and lessons identified. Staff told us about the incident and how lessons learnt were shared at the radiology team meeting and circulated by email.
- Between October 2015 and September 2016, outpatients and diagnostic imaging services reported 37 clinical incidents and 29 non-clinical incidents. The majority of these incidents were classed as no harm or low harm with four being classed as moderate harm. The rate of clinical incidents was lower than the rate of other independent acute hospitals we hold data for and the rate of non-clinical incidents reported was higher.
- From September 2015 to the time of our inspection, the hospital had not reported any incidents to the CQC under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Staff in the radiology department understood their responsibilities for reporting IR(ME)R incidents.
- Staff told us they received individual feedback from incidents and we saw in the minutes of team meetings, evidence of sharing and learning from incidents. This was a standard agenda item for all team meetings.
- We looked at an incident investigation report, which included a detailed chronology of events, investigation and root cause analysis. There were recommendations for immediate and future action and arrangements for shared learning.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood the principles of duty of candour and the importance of being open and honest with patients when mistakes were made.
- We saw evidence that duty of candour had been considered during the investigation of a radiology

incident. The radiology manager had informed the patient of the error even though the Radiological Protection Centre considered that the incident did not meet the requirements for duty of candour.

Cleanliness, infection control and hygiene

- From October 2015 to September 2016, there were no incidents of Meticillin-Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. difficile) or Meticillin Sensitive Staphylococcus Aureus (MSSA) within the hospital. There was one incident of Escherichia coli (E.Coli) during this period.
- All of the areas we visited were visibly clean, organised and uncluttered. We saw evidence of cleaning assurance stickers to indicate when a piece of equipment had been cleaned. We reviewed 10 pieces of equipment in the departments we visited and saw evidence of cleaning assurance stickers.
- Disposable curtains were used to separate the cubicles in the physiotherapy department. Curtains were labelled with the date they were put up and were changed every six months. The curtains we inspected had been replaced within the six month period.
- In the radiology department, we saw rooms had cleaning check sheets, which were signed to confirm that daily, weekly and monthly cleaning tasks had been completed.
- Antibacterial hand gel dispensers were available at the entrance to and throughout the main outpatient department and in clinical areas. There was signage encouraging visitors and staff to use the antibacterial gel. We saw appropriate containers for disposal of clinical waste and sharps were available in all areas we visited.
- Each department had an infection control link nurse and an assistant. Their role was to lead on infection prevention control issues in the area and keep staff updated with any change in practice.
- Staff completed infection prevention and control training as part of their mandatory training. There was good compliance with this training; compliance rates were 100% in radiology, 97% in outpatients and 92% in physiotherapy.
- Staff complied with 'bare below the elbows' policy, correct hand washing technique and use of hand gels. The hospital carried out monthly hand hygiene audits in all clinical areas. We saw the results displayed on notice boards in outpatient waiting areas. The radiology team had achieved a hand hygiene score of 94% for the month of January 2017. Outpatients achieved 90% compliance in their most recent audit.
- Personal protective equipment (PPE) was readily available in clinical areas such as gloves and aprons. In the radiology department, PPE equipment, including lead aprons, were clean and in good condition.
- There was a cleaning schedule in radiology. Machinery and equipment was cleaned after every patient and cleaned daily and weekly according to the schedule. This included the cleaning of lead aprons. Staff signed the schedule once they had completed each task.
- Treatment rooms, where clinical procedures were being carried out, had washable sealed floors. Consulting rooms on the ground floor used for screening and cosmetic surgery consultations had been fitted with impervious, washable flooring.
- Some consulting rooms in the outpatients department had carpeted floors. The outpatient department manager was aware that the presence of carpets was not in line with current infection control standards. Department of Health Guidelines (2013) Health Building Note 00-09: Infection control in the built environment states that "carpets should not be used in areas where body-fluid spillage is anticipated". The hospital build pre-dates the Department of Health guidelines, but managers told us that compliance with the guidelines would be a key factor in any planned refurbishments.
- This issue was not on the risk register, but was identified in the Infection Prevention and Control Gap Analysis undertaken in June 2016. The gap analysis identified the need to change flooring and a business case was developed in response. The regional team had approved the business case to replace the carpets by the time of inspection and the case was awaiting corporate approval. Management anticipated the programme for replacement to start in summer 2017. Standard operating procedures were in place and implemented for dealing with spillages.

Environment and equipment

Outstanding ☆

Outpatients and diagnostic imaging

- The radiology department was located on the lower ground floor. This could be accessed by stairs or a lift. The department had two ultrasound rooms, a room for mammography, computed tomography (CT), magnetic resonance imaging (MRI), X-ray and fluoroscopy. There was a main waiting area with access to toilets and sub waiting areas next to the ultrasound room and CT room with a changing room and toilet facilities that were accessible for patients with a disability. There were three radiology reporting rooms with adjustable lighting.
- Outpatient clinics were situated on the ground floor and the first floor. Both outpatient areas had large waiting areas with both low back and high back chairs in wipeable material. All waiting areas were bright and clean and patients had access to complimentary drinks.
- Physiotherapy had a separate area on the ground floor with a large waiting room. Staff would collect their patients from the waiting area and take them to the examination and treatment area.
- There was clear signage to all departments, including at the entrance to lifts.
- There had been recent investment of £2.8 million in new diagnostic imaging equipment in the radiology department. A business case for a new MRI and CT scanner had been successful and this had been installed within the last year. The CT scanner was capable of single rotation acquisition, which enabled imaging of the heart at any heart rate at significantly reduced radiation dose rates. This was safer for the patient.
- There were two mobile X-ray machines available, which could be used on the wards. Staff told us the equipment replacement programme was very good.
- We saw there were adequate numbers of lead aprons and thyroid collars available for use in the radiology department. Staff wore personal radiation dosimeters (a device that measures exposure to ionizing radiation). These were monitored regularly in accordance with legislation.
- Resuscitation trolleys were available in all departments we visited. All trolleys had been checked daily and weekly, were visibly clean and sealed with a numbered tag. We checked the contents of the trollies and found the contents were correct and all drugs and sterile equipment were within their expiry date. In the radiology department, separate resuscitation trolleys for adults and children were stored behind a screen in the corridor for ease of access.
- All equipment checked had been tested for electrical safety and had received a maintenance check within the last year. The outpatient manager kept a file of evidence for each piece of equipment which detailed when it was last checked, its condition and the date it was next due to be checked.
- We observed a programme of maintenance for all equipment in the radiology department, which was closely monitored by the radiology manager.
- Daily temperature checks were carried out in the plant room in radiology to ensure a constant temperature was maintained. There had been previous problems with overheating in this room and a new air conditioning unit had been installed.
- All areas were in a good state of repair and appeared well maintained. Areas were well organised, however, we found that not all storage areas, including those storing cleaning chemicals were secure. We raised this with service managers at the time of the inspection and they reassured us that the cleaning chemicals would be moved to a secure place.
- All fire extinguishers had been checked and maintained appropriately.

Medicines

- Medicines were stored safely in locked metal cabinets in outpatients. We checked a random selection and found they were all in date. There were no controlled drugs in outpatients or radiology.
- Medications that required refrigeration were stored appropriately in fridges. The medicines fridges were locked and there was a method in place to record daily fridge temperatures. We saw minimum and maximum fridge temperatures were recorded daily and were within the correct range. Staff were aware of what action to take if the fridge temperature was out of range. Plans were in place to move to a central fridge temperature recording system.

Outpatients and diagnostic imaging

- Consultants attending the outpatient department had access to prescription pads upon request. These were stored securely in a locked drugs cabinet and were signed in and out by the consultants.
- Contrast media was safely stored in the diagnostic imaging department and was in date. Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography.
- In the dirty utility room in outpatients, we found some disinfectant chlorine tablets in an unlocked cupboard. We were concerned that a patient could access this and it may cause harm. We informed a member of staff, who immediately moved it to a secure area.
- The pharmacy team were available to offer support from 8.30am to 4.30pm Monday to Friday and 9am to 1pm on Saturdays. An on-call pharmacist was available outside of these hours.

Records

- There was a single set of fully integrated paper records for all patients with the exception of physiotherapy patient records, which were held on an electronic system.
- For ease of access, paper records for patients seen in the last three years were stored securely in the medical records department on the hospital site. Records for patients seen longer ago than three years ago were stored securely in an off-site archive facility.
- A tracer system was used to record all movement of records within the hospital to enable them to be easily located. Staff told us issues arose when records were moved between departments without updating the tracker. The medical records manager was aware of the issue and had taken action to improve this. Heads of departments had been alerted and asked to remind staff to inform medical records so that the tracer could be updated. This issue was on the risk register.
- Records were transported around the hospital in a trolley and were delivered to secure areas within each department. In the outpatients department, records were either held in the consulting or treatment room with the relevant practitioner or stored securely in the outpatient manager's office.
- Nurses in outpatients told us it was rare for records to be unavailable for scheduled appointments. Information provided to us by the hospital showed that the percentage of patients seen in the outpatients department without all relevant records was less than 1%. Records kept off site could be ordered the day before and would be delivered by 7am the following morning. In the event that records were not available, imaging and pathology results were available electronically and correspondence was requested from the consultant's secretary.
- We reviewed six sets of paper records in the outpatients department and six sets of electronic records in the physiotherapy department. The electronic records in physiotherapy were thorough and in line with professional standards. Paper records were in good condition and completed thoroughly. All records contained patient details, past medical history, medication, allergies and drug intolerances and discharge planning. We had difficulty reading some of the handwriting in some paper records and the consultant's signature was not always accompanied by their printed name.
- There had been a series of information governance incidents involving patient information being sent to the wrong GP. Managers had made staff aware of this issue and provided training in the correct procedures to avoid reoccurrence. This issue was included on the risk register.
- Staff received information governance and health records training. Training figures provided by the hospital showed that 93% of radiology staff and 88% of outpatients and physiotherapy staff had received information governance training. Health records training was 100% for radiology, 94% for physiotherapy and 91% for outpatients.

Safeguarding

- Staff we spoke with were aware of their roles and responsibilities in relation to safeguarding. They were able to identify different types of abuse and were aware of how to escalate concerns.
- We saw laminated flow charts for staff to follow should they have a safeguarding concern. These were displayed on a notice board in the outpatient manager's office.

Outpatients and diagnostic imaging

- Registered health professionals have statutory duties around identifying and reporting cases of Female genital mutilation (FGM). We saw information displayed on the notice board of the outpatients manager's office regarding FGM and staff told us they had received awareness training as part of their safeguarding training. We were assured staff would know what to do if they identified a woman with FGM.
- The adult safeguarding lead for this hospital was the matron. In her absence, the deputy matron held this responsibility.
- Staff completed vulnerable adults training and safeguarding children and young people training as part of the Nuffield Health mandatory training programme. The level of their training was dependant on their role.
- From information provided by the hospital, we saw that staff compliance with safeguarding vulnerable adults Level 1 training was 100% in radiology, 97% in outpatients and 92% in physiotherapy.
- Compliance with safeguarding children and young people Level 2 training was 82% in outpatients, 76% in physiotherapy and 73% in radiology. The hospital had a plan to reach 95% compliance by the end of March 2017. The matron, deputy matron and the resident medical officers were all trained to safeguarding children Level 3.
- During the period October 2015 to September 2016, there were no safeguarding concerns related to this hospital reported to the CQC.

Mandatory training

- Mandatory training included topics such as fire safety, manual handling, infection prevention, health record keeping, information governance and life support training. Mandatory training was automatically allocated to staff depending on their role, using an online system.
- Department managers were able to access the online system to monitor and manage staff compliance with mandatory training. The system generated alerts to managers and staff when training was due or overdue.
- The online system gave an overall rating for each training title by department using a red, amber, green (RAG) rating scheme. Green showed training compliance of 85% - 100%, amber 80% - 84% and red 0% - 79%. This enabled managers to see at a glance, which areas were of concern and required action.
- Staff we spoke with confirmed they were up to date with their mandatory training. They said training was accessible and the majority could be completed through e-learning, although some training was delivered in face to face sessions.
- Information provided by the hospital showed that compliance with mandatory training was good for staff in outpatients and diagnostic imaging, with most training compliance rated as green. Basic life support compliance was 70% in outpatients, 86% in physiotherapy and 100% in radiology. Intermediate life support training compliance was 80% in radiology and 86% in outpatients.
- Paediatric basic life support training compliance was 67% in physiotherapy. Paediatric intermediate life support (PILS) training compliance in outpatients and diagnostic imaging was 29% (4/15 staff). An additional PILS course was scheduled for March 2017. A recent change in corporate policy had extended the range of staff expected to complete paediatric resuscitation training and training provision had been increased for 2017.
- Training in all areas of resuscitation were expected to reach or exceed the hospital target by March 31st 2017.

Assessing and responding to patient risk

- The hospital had resident medical officer cover, which was provided 24 hours a day, seven days a week.
- Staff in the outpatient, physiotherapy and radiology departments knew how to get help for a patient who became unwell. Staff could alert and summon the emergency team by pulling the triangle switch situated in each clinic room.
- All health and safety risks were assessed in outpatients and diagnostic imaging services. Each department had a risk assessment folder, which identified risks and measures put in place to minimise risks. We saw examples of completed risk assessments in the radiology department to minimise radiation risks to patients and staff. Risk assessments were regularly updated.

Outpatients and diagnostic imaging

- The radiology manager was the radiation protection supervisor (RPS) and was responsible for ensuring compliance with the arrangements made by the radiation employer under IRR99.
- The RPS had good access to advice from the radiation protection advisor (RPA). The RPA undertook the annual radiation protection audit at this hospital. We reviewed the last RPA audit completed in July 2016 and saw the hospital was fully compliant.
- In the radiology department, we saw checks were in place to ensure the service identified women who may be pregnant. Signs were displayed in waiting areas, requesting women to discuss with the radiographer if they thought they might be pregnant.
- Prior to carrying out a diagnostic image, radiography staff carried out a six point check to identify the correct patient. This included patient's name, address, date of birth, examination, clinical indications and GP. A safety questionnaire was completed for all patients prior to an MRI or CT scan.
- The outpatients department was using a safety checklist for patients undergoing minor surgical procedures. The checklist had been devised by modifying the National Patient Safety Agency surgical safety checklist.

Nursing and AHP staffing

- There were sufficient qualified, skilled and experienced staff to meet people's needs. Senior staff in all departments told us staff worked flexibly to accommodate the needs of the service.
- Data submitted by the hospital for September 2016 showed that the outpatient department employed 5.9 whole time equivalent (WTE) registered nurses and 3.0 WTE health care assistants. There were no vacancies in the outpatient department at the time of the inspection.
- Between October 2015 and September 2016, the outpatients department did not use any agency nurses or health care assistants.
- There were no vacancies in radiology at the time of the inspection. One new member of staff had been appointed and was due to start soon. We spoke to one bank and one agency radiographer during the inspection. Both had completed role specific training and had a comprehensive induction.
- The physiotherapy team was fully staffed. Regular bank staff were used to fill the weekend on-call rota to provide ward cover. These bank staff received a ward induction.
- All outpatient and radiology departments had administrative staff to support them.

Medical staffing

- There were 321 consultants operating under practising privileges at Nuffield Health Leeds Hospital. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there. Information supplied by the hospital showed 100% of medical staff had their registration validated in the last 12 months.
- All consultants held a GMC licence and were required to abide by the Nuffield Health practising privileges policy. In order to maintain practicing privileges, they needed to provide the organisation with evidence to demonstrate they met the criteria.
- A radiologist was available daily in the radiology department to report on images.
- A resident medical officer (RMO) was onsite 24 hours a day, seven days a week.

Emergency awareness and training

- There were weekly fire alarms and emergency call tests. All departments we visited had a nominated fire warden.
- There was an overarching business and essential services continuity plan for the hospital, which included outpatient and diagnostic imaging services. Staff were aware of the plan and where to find it on the intranet.

Are outpatients and diagnostic imaging services effective?

The effective domain was inspected, but was not rated in line with our inspection approach.

Evidence-based care and treatment

- Policies and procedures for outpatients and diagnostic imaging had been developed and referenced to the National Institute for Health and Care Excellence (NICE)

and national guidance. All new NICE guidance was circulated to the relevant heads of department to check that their policies and procedure were meeting the guidance.

- We viewed policies for the radiology department. These included, 'Safety procedures in radiology' and 'Identifying the at risk patient prior to contrast administration'. All polices we viewed were in date and available for staff on the intranet. Some paper copies of procedures were kept in a file in the X-ray room.
- The radiology department did not participate in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focussed assessment and accreditation programme designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- The radiology department operated a 'pause and check' process before carrying out procedures. This involved checking patient identification, whether staff were viewing the correct records, and questioning whether the procedure was appropriate. We saw posters displayed on the walls in radiology department, as a reminder to staff.
- The radiology service considered national guidance from the Department of Health in regard to setting local diagnostic reference levels (LDRLs) in practice. This provided radiographers with information about the radiation dose levels expected for examinations.
- We observed that DRLs were displayed on the notice board in the radiologydepartment and all staff were able to articulate the DRLs. We saw evidence that local dose reference levels were regularly audited in the radiology department.
- Quarterly audits were carried out in the radiology department, which included chaperone, clinical waste, patient identification and dignity awareness. We saw the results for the previous four quarters that showed radiology had scored 100% in all areas apart from two scores, which were 96% and 98%. The radiology department also audited image quality and consent to examination. Audit results were discussed with staff at team meetings and included any actions for improvement.
- Quarterly audits carried out in the outpatients department were chaperone, clinical waste, medical records, patient identification and dignity awareness. The results for the previous three quarters that showed outpatients scored between 87% and 100% in all areas.

Pain relief

- Staff in the physiotherapy department asked patients about their pain levels before and after treatment and used this to measure the effectiveness of their interventions.
- Physiotherapists were qualified in providing acupuncture treatment to patients to reduce pain levels.
- Local anaesthesia was used for some minor procedures that took place in the outpatient department.

Patient outcomes

- Staff in the physiotherapy outpatient department used patient reported outcome measures to measure patient outcomes following knee or hip surgery. They used the Oxford Knee Scoring Tool and the Oxford Hip Scoring Tool, which contain 12 questions on activities of daily living to assess function and pain.
- Physiotherapists set individual goals with each patient receiving treatment for a musculoskeletal condition. Goals were based on improving function.
- Physiotherapy pre-assessment sessions were offered to patients due to have knee or hip surgery. These sessions were designed to prepare patients for their experience and give them an opportunity to ask any questions or talk through any issues they were worried about such as what to expect following surgery, length of stay and how long their dressing would be kept on.
- The hospital contributed data to the Private Healthcare Information Network (PHIN). PHIN collects data from independent hospitals and produces safety and quality indicators such as mortality rates, readmission rates and patient feedback for benchmarking purposes.

Competent staff

- Staff told us they were well supported to maintain and further develop their professional skills and experience. Radiographers told us they were able to access continuing professional development.

Outpatients and diagnostic imaging

- Appraisal rates for the year January 2015 to January 2016 were 100% for nurses and health care assistants working in the outpatients department. All staff we spoke with said they had completed their annual appraisal and they found this a useful process.
- There was a robust system in place for checking and validating staff registration. The hospital was 100% compliant for nurses and radiographers in outpatients and diagnostic imaging. Nursing staff working in outpatients told us they were supported in achieving revalidation.
- There was an induction policy, which included induction procedures for new starters,bank and agency staff. Staff told us they had completed an induction programme and had specific competencies to complete for their role. We saw the competencies for the role of physiotherapy assistant.
- All radiographers involved in contrast media injections had undertaken an intravenous cannulation course approved by the College of Radiographers.
- The physiotherapy team received an in-house training session every two months. Physiotherapists were able to access funding for other developmental training from a central fund.
- The radiology and outpatient departments both supported students on placement.

Multidisciplinary working

- There were good working relationships between staff of all disciplines in the outpatients department.
- Staff working in radiology told us they had very good communication with the consultant radiologists who worked at the hospital.
- Physiotherapists worked closely with the surgical consultants for the benefit of patients.

Seven-day services

- The radiology department was open Monday to Friday 7.30am to 8.30pm and occasionally on Saturday mornings. For CT and MRI scans, the on-call rota was covered by three members of staff, but it was rare to receive a call. Another radiographer was due to commence soon and would be joining the rota once they had received training.
- The main outpatients department was open from 8am to 9pm, Monday to Friday.
- The outpatient physiotherapy department was open 8am to 7pm Monday to Thursday and 8am to 5pm on Fridays. Staff told us evening appointments up until 7.30pm were available on Thursdays. There were no clinics at the weekend.

Access to information

- All imaging and pathology results were available electronically. Images were stored on a picture archiving and communication system (PACS) and could be sent to other hospitals using an image exchange portal (IEP). The IEP could also import images in from other sources.
- If there was no radiologist available for urgent reporting of images, the hospital sent the images to an offsite reporting company.
- A specialist mammography radiologist attended when the breast clinic was running, to report on the images. If they were not available, the images were sent to an external company.
- Pathology services were available on the hospital site, which included blood transfusion, chemistry, haematology microbiology and histology. The service had received clinical pathology accreditation from the United Kingdom Accreditation Service (UKAS).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for verbal consent prior to radiology procedures and this was recorded in the patient's record. Consent was also documented in the physiotherapy records we reviewed.
- Staff received consent training. Figures provided by the hospital showed the 100% of radiology staff, 91% of staff in outpatients and 96% of physiotherapy staff had completed this training.
- Staff we spoke with had a good understanding of their responsibilities with regard to the Mental Capacity Act (MCA). Staff were able to carry out a level one mental capacity assessment. The outpatient manager told us that if there were concerns about a patient's capacity, the consultant would undertake a level two assessment prior to gaining consent for treatment.

Outstanding ☆

Outpatients and diagnostic imaging

- There was good compliance with staff training in MCA and Deprivation of Liberty Standards (DoLS). MCA training compliance was 100% for radiology and outpatients and 86% for physiotherapy. DoLS training was 100% for radiology and physiotherapy and 91% for outpatients.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

Compassionate care

- We spoke with 11 patients and relatives. They were all happy with the care and treatment they received at this hospital.
- Prior to and during this inspection we provided comments cards for patients to tell us what they thought about this service. We received 103 comment cards for outpatients and diagnostic imaging services and they were all extremely positive. There were no negative comments.
- Patient comments included, “Wonderful care”, “Discreet and friendly staff”, “Radiology team were so caring and patient”, “Brilliant experience, I cannot fault it”, “Everyone from reception staff to consultants treated me with respect and dignity”, “The physio staff were excellent” and “Brilliant care, responsive to my individual needs”.
- Patients told us they were treated with kindness, dignity and respect. They said they would be happy to recommend this service to others and would be happy to come back again if further treatment was needed.
- We observed staff communicating with patients and their families in a respectful and considerate manner. Reception staff were welcoming and friendly and patients told us they were courteous.
- We observed curtains round the inside of the door in the ultrasound and mammography room to give privacy to patients when removing clothing.

Understanding and involvement of patients and those close to them

- All patients we spoke with said they felt informed about their care and treatment.
- Patients said staff explained things fully to them and had time to answer their questions. They did not feel rushed.
- We saw recorded in patient’s records, that risks, benefits and possible side effects of the treatment were explained to the patient.
- We observed staff explaining treatment options to patients and giving them a choice in how they wished to proceed. Where appropriate, costs for examinations were also discussed prior to decisions being made.

Emotional support

- Staff in radiology were aware that some patients felt uncomfortable in the confined space of the CT and MRI scanner and did as much as possible to reassure and support patients.
- Nursing staff in outpatients told us part of their role was to support patients and relatives when being given bad news by the consultant. They said they had time to support patients.
- Psychological support was available for patients receiving cosmetic, bariatric or breast cancer treatment.
- The hospital had a policy in place for the use of chaperones. We saw chaperones were available in the departments we visited.
- There was no chapel at the hospital; however, information was displayed in outpatient waiting areas offering prayer and reflection space to patients and carers if they needed it. Staff spoke compassionately about their patients and had a clear understanding of the impact that a person’s care, treatment or condition could have on their wellbeing and on those close to them, both emotionally and socially.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

Service planning and delivery to meet the needs of local people

Outstanding ☆

Outpatients and diagnostic imaging

- The hospital received referrals predominately from the local clinical commissioning groups and NHS acute trusts.
- The outpatient department waiting areas were well planned with patients directed to the area nearest to their consulting room. Reception staff were able to view all waiting patients.
- The radiology department provided a full range of diagnostic imaging tests and x-rays, including MRI and CT scans. This meant that patients could get the majority of tests they needed on one site.
- Late clinics provided good access to services for patients who worked full-time, meaning they did not have to take time off work to attend appointments. Patients could obtain appointments with very little waiting time. For example, physiotherapy appointments were available within 48 hours.
- A private car service was available for self-funded or insured patients who had difficulty getting to the hospital. This allowed patients to arrive for their appointments stress-free and in a timely manner.

Access and flow

- For the period October 2015 to September 2016, the referral to treatment time (RTT) for patients on incomplete pathways waiting 18 weeks or less at this hospital, was consistently 95% or higher. This was similar for patients on non-admitted treatment at 97% or higher.
- All patients we spoke with in outpatients and diagnostics imaging services told us that they had not waited long to be seen. Many of the patient comment cards we reviewed commented on how they had been seen promptly. In all waiting areas, there were notices on the wall, which told patients to enquire at the reception desk if their appointment was delayed by more than 15 minutes.
- There was no waiting list for physiotherapy appointments. Patients were able to use the online booking system and could access an appointment within 48 hours. Patients attending physiotherapy outpatients following surgery were booked in advance, based on their planned date for surgery.
- The radiology department offered patients appointments over the telephone to ensure the date and time suited the patient. Administration staff in the radiology department told us the number of patients failing to attend appointments was low. They attributed this to their method of appointing.
- Radiography staff booked their own patients in for MRI scans. Referrals were vetted using a protocol to ensure they were appropriate and to determine if the scan was routine or urgent. Urgent scans were normally carried out the same day. Staff told us they were always prepared to stay at work longer if necessary to ensure urgent patients received their imaging.
- Kidney function was checked prior to administering intravenous contrast. Staff told us blood tests could be arranged and the test results were available on the same day.
- Staff told us there were no waits for urgent radiology appointments and routine patients were normally seen within two weeks. At the time of the inspection there was a three week wait for musculo-skeletal ultrasound, however, staff said this was unusual and was due to radiology staff being on annual leave.
- Patients we spoke with confirmed they had been offered a choice of appointment dates and times that suited their needs and that they had accessed them in a timely manner.
- A consultant-led one-stop breast clinic was held on Thursday evenings, offering mammography and ultrasound biopsy. Breast care specialist nurses were available to support this clinic.
- The radiology manager carried out daily checks to ensure all images on the system had been processed and were reported in a timely manner.
- Information provided to us by the hospital for the months of April 2016 to September 2016, showed that 0.1% of radiologist sessions were cancelled. The percentage of clinics cancelled in the outpatients departments ranged between 1.1% and 1.8%. There was a peak in July 2016 when 4.3% of clinics were cancelled due to the impact of consultant sick leave and the holiday period.

Meeting people's individual needs

Outstanding ☆

Outpatients and diagnostic imaging

- The outpatient department manager was the lead for dementia at the hospital and had made some positive changes to the environment in outpatients. A quiet waiting lounge, separate to the main waiting areas had been created with memory boards on the wall. Patients with dementia were able to use this room if they were feeling unsettled in the main waiting area. Memory scrapbooks were also available.
- We saw dementia-friendly signage and large clocks installed in outpatient areas. Toilet facilities had been adapted with red toilet seats and dementia friendly signage on the inside and outside of the door.
- The outpatient manager was passionate about providing good care for patients with dementia and was a member of the local Dementia Action Alliance, an organisation to share best practice and take action on dementia.
- Staff in the radiology department made adjustments for patients with disabilities. A hoist was available and additional member of staff would provide help if needed. Staff told us they allowed extra appointment time for patients with a disability.
- Information leaflets and signs were displayed in waiting areas to inform patients of the chaperone service.
- An examination couch for bariatric patients was available in the cardiology area of outpatients.
- We saw a sign for a hearing loop in the physiotherapy waiting area; however, reception staff did not know where it was or how to use it.
- Telephone and face to face interpreting services were available for patients whose first language was not English. Staff said the system worked well and it was easy to book. We observed two interpreters assisting patients during our visit. We heard an interpreter speaking to a patient over the phone to give them advice and information about their procedure in radiology.
- Complimentary drinks were available in all outpatient waiting areas.
- A good range of patient information leaflets were available in outpatient waiting areas. These included information on cosmetic surgery, translation services, how to make a complaint and how to find a room for prayer and reflection.

Learning from complaints and concerns

- See the Surgery section for main findings.
- The departments had very few formal complaints. There had been one complaint between April and December 2016. We saw information leaflets for patients on how to make a complaint displayed in all outpatient waiting areas.
- Staff told us that they dealt with patient concerns immediately to resolve them quickly where possible. Any formal complaints were shared with staff at team meetings, which included feedback and learning. Compliments were also shared with staff at team meetings.
- Staff were able to tell us how action was taken following a complaint from a patient about a consultant's attitude.

Are outpatients and diagnostic imaging services well-led?

Good ●

Leadership and culture of service

- The hospital director was new in this role having joined the hospital in 2016. Outpatients, radiology and physiotherapy departments all had dedicated managers who reported to the hospital matron. The physiotherapy manager also managed the health screening service.
- Staff we spoke with had been introduced to the new hospital director and regularly had contact with the matron and deputy matron. They said that the senior management team was very approachable and accessible.
- All staff spoke highly of their line managers and felt they had a good relationship with them. Staff said that managers thanked them for their hard work, which made them feel appreciated and valued.

Outpatients and diagnostic imaging

- We found a positive culture in outpatients and diagnostic imaging services. Staff were proud of the services they delivered to patients and were happy to work at the hospital.
- Staff confirmed they had not experienced any bullying whilst working at this hospital. They said they felt able to express any worries or concerns to their managers.
- The hospital held an annual 'leadership MOT' and encouraged staff to provide feedback on their line manager and the senior management team.

Vision and strategy for this this core service

- The local vision was to become the private hospital of choice in Leeds by ensuring high quality care that is safe, effective and personalised to the individual needs.
- The hospital had six core beliefs and their values were to be connected, aspirational, responsive and ethical. These values were new and the senior management team were in the process of briefing staff on the new values. The hospitals beliefs and values formed the basis for staff appraisals and recruitment.

Governance, risk management and quality measurements

- See the Surgery section for main findings.
- There was a hospital risk register, which identified risks for all departments. The hospital wide risk register had no specific items that related only to outpatients and diagnostic imaging services.
- Outpatients and diagnostic imaging services had not previously maintained their own risk registers; however, managers told us they had recently started to develop their own registers.
- Any health and safety issue, which required escalating, would be taken to the health and safety meeting by the heads of department. Managers told us the issue would be discussed at this meeting and a decision taken on whether it needed to be included in the overarching hospital risk register. Risks could also be escalated through the clinical governance group.
- The outpatients, physiotherapy and radiology departments all held monthly team meetings with their staff. Agenda items included incidents and complaints, audit, risk management, training and professional development. We observed a team meeting in the radiology department and found it was very effective with good communication between all staff in the team.
- Audit results were discussed at team meetings and we saw that actions to improve the quality of services were made.

Public and staff engagement

- Staff told us they felt valued and morale was good in all departments we visited. Mangers engaged regularly with staff informally and formally through monthly team meetings. A monthly team brief was circulated to staff and discussed in team meetings.
- An annual staff survey was carried out as part of the 'leadership MOT'. Results were compared with the previous year. For any areas where responses had declined or were not positive, there was an action plan for improvement.
- An employee assistance programme was offered to staff, which provided confidential counselling support, flexible working, phased return for staff returning from long term sick and access to occupational health services. Staff we spoke with told us they felt well supported through personal or ill health issues.
- Staff told us they appreciated some of the benefits of working at this hospital such as free gym membership and medical insurance. Staff were also recognised for their long service with awards.
- For the period October 2015 to September 2016 the outpatient nurse and health care assistant turnover rate was slightly higher than the average of other independent acute hospitals we hold this type of data for in the same period.
- Customer focus group meetings were held monthly. We saw in the minutes results of patient satisfaction surveys were discussed at these meetings.
- In order to gather the views and experiences of patients using their services, the hospital was planning to hold a patient forum group. We saw information displayed in waiting areas to encourage patients to take part.
- The hospital participated in the Friends and Family test. There was a specific feedback form for outpatient departments, which was handed to patients by reception and clinical staff. The feedback form asked patients how likely they were to recommend this hospital to friends and family on a scale of 0 -10. There was a 96% satisfaction rate out of 145 responses.
- The physiotherapy department encouraged patients to participate in their patient satisfaction survey. The results were analysed every month to identify areas for improvement and shared with staff at team meetings.

Outstanding ☆

Outpatients and diagnostic imaging

- We received no whistleblowing concerns from staff in the previous 12 months. Staff we spoke with had completed training in whistleblowing and were aware of the whistleblowing policy and where to locate it.

Innovation, improvement and sustainability

- An investment of £2.8 million in new diagnostic imaging equipment in the radiology department had led to improvements. The new CT scanner was capable of single rotation acquisition, which enabled imaging of the heart at any heart rate at significantly reduced radiation dose rates, which was safer for the patient.
- The radiology department had introduced a new service, CT colonography, which used low dose radiation CT scanning to obtain an interior view of the large intestine. Staff had received specific training in order to provide this service. This view would normally only be seen using a more invasive procedure involving endoscopy.

Outstanding practice and areas for improvement

Outstanding practice

- The lead children's nurse had devised a leaflet for children and young people to guide them through their surgery. She hoped to take this to the national CYP meetings to discuss other Nuffield Health hospitals using the same.
- The critical care team had developed a training programme on the management of a deteriorating patient; they provided this training to hospital ward staff and to staff at other Nuffield Health hospitals.
- The hospital utilised professional development resources to develop education programmes to improve patient safety; for example related to diabetes management, catheterisation, medicines management and quality of documentation. Further education at NVQ and degree level was encouraged and taken up by staff members.
- The hospital maintained strong relationships with local healthcare partners resulting in active roles in areas such as antimicrobial stewardship, infection prevention, professional development and education. One outcome involved the development of the 'catheter passport' to improve the quality of catheter care after discharge from the hospital.
- The radiology department had introduced a new service, CT colonography, which used low dose radiation CT scanning to obtain an interior view of the large intestine. Staff had received specific training in order to provide this service. This view would normally only be seen using a more invasive procedure involving endoscopy.
- The hospital was the first independent hospital in the country to undertake navigational spinal fusion. The navigational equipment assisted the surgeon to achieve increased accuracy of surgical procedures.
- 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. The pre-assessment process included a full health assessment. During this assessment, staff were able to identify patients who were at risk of developing diabetes or cardiac conditions. We were told of patients diagnosed with conditions they were unaware of as an outcome of the health assessment. Patients were provided with an overall health report to discuss with their GP.
- The hospital employed a full-time coder to support accurate and timely data submission to the Private Healthcare Information Network.

Areas for improvement

Action the provider SHOULD take to improve

We found areas of practice that require improvement overall:

- The hospital should ensure that consultant documentation in the patient's record is timely, legible and signed.
- The hospital should ensure that paediatric resuscitation training levels are achieved for all relevant staff, in line with the recent corporate training policy change.
- The hospital should consider Health Building Note 00-09 guidance related to flooring in clinical areas and accessibility of clinical hand wash basins, where applicable.
- The hospital should formalise a patient transfer arrangement with the local NHS trust.

In Critical Care

- The hospital should evidence their effectiveness in critical care and cardiac surgery outcomes by participating in relevant national benchmarking databases.

Outstanding practice and areas for improvement

- The hospital should consider auditing the effectiveness of the critical care outreach service.

In Services for children and young people:

- The hospital should review systems to evidence their effectiveness in paediatric surgery outcomes, including relevant national benchmarking databases.

In Outpatients and Diagnostic Imaging:

- The hospital should ensure that all cleaning chemicals are stored safely and securely.
- The hospital should review systems to ensure staff are aware of how to manage the hearing loop.