

Nuffield Health

Nuffield Health Tees Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Nuffield Health Tees Hospital is part of the Nuffield Health Group which operates as a non-profit organisation. It primarily serves the communities of Stockton on Tees, Middlesbrough and Darlington and accepts patient referrals outside of the catchment area. The hospital has 30 patient bedrooms configured into one ward which is used for either day cases or in patients. It provides acute surgical care for adults, diagnostic services, outpatient facilities and physiotherapy. Referrals are received from self-funding patients, patients with medical insurance and NHS patients via Choose and Book. Referrals for all available imaging modalities are accepted in accordance with statutory regulations from medical referrers and some locally registered non-medical referrers. Patients may self-refer for Breast Screening Mammography (Asymptomatic only). NHS patients account for 60% of the total patient mix.

There are 205 staff and 135 consultants working at the hospital. The senior leadership team comprises a Hospital Director, Matron and Finance Manager. The hospital is supported by experts within the Nuffield Hospital Division Group and externally from local NHS providers.

We inspected the hospital from 11 to 12 November 2014 and undertook an unannounced inspection on 19 November 2014. We inspected this hospital as part of our first wave independent hospital inspection programme. The inspection was conducted using the Care Quality Commissions new inspection methodology.

Overall the care and treatment patients received at Nuffield Health Tees Hospital were safe, effective, caring, responsive and well-led.

Our key findings were as follows:

- Medical and nurse staffing levels were adequate on the ward, theatres, outpatients and diagnostic services. Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.
- Arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found that all areas we visited were clean. There were no hospital acquired infections during 2013/14.
- There were no unexpected patient deaths during 2013/14.
- Processes were in place to ensure patients nutrition and hydration was effectively managed prior to and following surgery. Where required access to dietician input was available. Patients gave positive feedback about the choice and quality of food they received
- There was sufficient equipment to ensure staff could carry out their duties. Processes were in place for monitoring and maintaining equipment.
- Records were well maintained and documents were completed to a good standard including completion of patient risk assessments.
- Staff understood their responsibilities to raise concerns and record patient safety incidents and near misses. There was evidence of a culture of learning and service improvement.
- Medicine management arrangements were in place. Medicines were stored securely and staff were competent to administer medicines.
- There were systems for the effective management of staff which included an annual appraisal. All doctors were appropriately vetted to ensure they had the skills to undertake surgical procedures.
- The hospital undertook a programme of local clinical audits depending on risk assessments. These covered a range of areas including infection prevention and control, medicines management and audits of pathology, radiology and clinical services.
- Senior and departmental leadership at the hospital was good. Leaders were aware of their responsibilities to promote patient and staff safety and wellbeing. Leaders were visible and there was a culture which encouraged candour, openness and honesty.

Summary of findings

- Integrated governance arrangements enabled the effective identification and monitoring of risks and action was taken to improve performance. Progress on achieving improvements were reported and measured through the relevant management boards with oversight and scrutiny from the provider's quality governance committees with ultimate responsibility resting with the group chief executive and board.

In addition to the above, we saw areas of good practice:

- Physiotherapists were trialling a new exercise group for patients with back pain and had introduced pre-operative group sessions for patients undergoing joint replacements with an aim to help patients achieve realistic expectations of post-operative therapy and recovery.
- Additional nurse-led pre-assessment clinics had been introduced to enable patient's sufficient time to be assessed and reduce delays in surgery.
- Patients undergoing cataract surgery received staggered appointment times to reduce patients fasting pre-operatively for long periods.
- Flexibility was offered around outpatient appointments and aligned to other investigations for example; phlebotomy appointments were offered to coincide with a visit to x-ray.
- The governance structures enabled national learning from other hospitals in the Nuffield Health Group. This had led to changes to improve practice in areas such as ophthalmology.
- Staff had access to an Employee Assistance Programme which provided a variety of services for employee wellbeing and performance.

However, there were some very limited areas of poor practice where the provider needs to make improvements:

The hospital should :

- Ensure all staff follow the hospital's infection prevention and control policies and procedures particularly 'bare below the elbows' policy and the wearing of personal protective equipment.
- Ensure staff receive training and are aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and apply these in practice where appropriate.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating Why have we given this rating?

Surgical services were safe, effective, caring, responsive and well-led. There was an open and transparent culture for reporting and learning from incidents and complaints. Lessons learnt were used to feed into service improvements.

Surgical areas were clean and there were arrangements in place for the prevention and control of infection. Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.

Medicine management arrangements were in place. There were reliable systems and practices to keep patients safe and safeguarded from abuse. Staff were trained to recognise and respond to warning signs of rapid deterioration of a patient's health.

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. There were no unexpected deaths during 2013/14.

Staff awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards was limited, however, the hospital had identified a MCA and dementia lead to take this work forward.

There was effective communication and collaboration between multidisciplinary teams. Patients received care and treatment from competent staff. Patients were risk assessed appropriately and effective pain relief arrangements were in place.

There were effective processes to ensure patients had timely access to assessment, diagnosis and treatment. Services ran on time and patients were kept informed about any disruptions.

There were very few complaints arising from patient experiences in surgical services. Complaints were handled effectively and lessons were learned from concerns and complaints

Staff were aware of the hospital's vision and strategy and there were good arrangements for monitoring the service. There was strong local leadership of the service and quality care and patient experience was seen as all the staff's responsibility.

Summary of findings

Outpatients and diagnostic imaging

The hospital recognised the importance of patient and staff feedback and there were mechanisms to hear and respond to patient views. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Patients gave positive feedback about the care they received. The service was caring and compassionate. Incidents were reported, investigated and lessons learned.

Cleanliness and hygiene was within acceptable standards. Most staff adhered to infection control policies however we found the medical laboratory assistants did not routinely wear gloves for blood sampling.

There were sufficient and well trained staff to ensure patients were treated safely. Medical records were available for out-patient clinics and were completed to a good standard.

Care and treatment was evidence based and patient outcomes were within acceptable limits. Staff had the correct knowledge and skills to do their job. Staff administering radiation were appropriately trained and supervised in accordance with legislation. Staff had some understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards but had not received any formal training in this area. The hospital was in the process of planning training for all staff.

Patients were seen quickly for urgent appointments and clinics were rarely cancelled at short notice. Systems were in place to capture concerns and complaints and action taken to improve patient experience.

The service was well-led. There was an open and supportive culture. Managers provided clear leadership and staff felt empowered to express their opinions and were listened to.

Nuffield Health Tees Hospital

Detailed findings

Services we looked at

Surgery; Outpatients and diagnostic imaging

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Detailed findings from this inspection

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Detailed findings

Background to Nuffield Health Tees Hospital

Nuffield Health Tees Hospital was opened in 1981 by Nuffield Health and is registered as a non-profit organisation. It primarily serves the communities of Stockton on Tees, Middlesbrough and Darlington and accepts patient referrals outside of the catchment area. The hospital provides acute surgical care for adults, diagnostic services, outpatient facilities and physiotherapy for private and NHS patients. NHS patients account for 60% of the hospital's workload. The surgical mix is typical of an independent sector hospital, though the hospital's largest specialty is orthopaedics with 40% of theatre episodes.

The hospital has 30 patient bedrooms configured into one ward which is used for either day cases or inpatients. There are two clean-air operating theatres and a four bay

recovery area. The hospital provides an endoscopy service, outpatients, pre-assessment and diagnostic services. The hospital contracts with an external agency to provide mobile MRI scanning two days per week.

There are 205 clinical and administrative staff and 135 consultants from a variety of specialties who work at the hospital.

The hospital has not taken part in any special reviews or investigations by the CQC at any time during 2013/14. The last inspection carried out in December 2013 showed the hospital was meeting all standards of quality and safety.

The inspection team inspected the following two core services at Nuffield Health Tees Hospital:

- Surgery
- Outpatient and diagnostic imaging

Our inspection team

Our inspection team was led by:

Inspection Manager: Sandra Sutton, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultants in surgery and anaesthetics, senior manager from another independent provider, nurses, and expert by experience who had experience of using healthcare services.

How we carried out this inspection

We carried out the announced inspection between 11 and 12 November 2014 along with an unannounced visit at the hospital on 19 November 2014 between 7.30pm and 9pm. We talked with patients and members of staff, including ward managers, nursing staff (qualified and unqualified) medical staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patient's clinical records.

Prior to the announced inspection, we reviewed a range of information we had received from the hospital. We also asked the local clinical commissioning group to share what they knew about the hospital.

Detailed findings

Facts and data about Nuffield Health Tees Hospital

Nuffield Health Tees Hospital primarily serves the communities of Stockton on Tees, Middlesbrough and Darlington and accepts patient referrals outside of the catchment area.

The hospital has 30 patient bedrooms configured into one ward. There were two operating theatres and a four bay recovery area. There was one dedicated endoscopy room. Outpatient areas consisted of eight consulting rooms, a treatment room, pathology laboratory and pharmacy.

Staffing

At 31 July 2014 the hospital had:

- 135 doctors and dentists working under the rules of practising privileges.

- 14.20 full time equivalent (WTE) nurses in inpatient departments, 16.65 in theatres and 2.60 in outpatients.
- 19 Allied Healthcare Professionals
- 8.04 WTE healthcare assistants in inpatient departments and 1.60 in outpatients.

Activity

Between July 2013 and June 2014 the hospital had:

- 1,512 discharges following an overnight inpatient stay.
- Nine discharges following a day-case stay.
- 6,506 visits to the operating theatre.
- During 2013/14 the hospital carried out 218 hip replacements and 253 knee replacements.
- From January 2014 to September 2014 the hospital outpatient department saw 21,467 patients. 5192 were new appointments and 13,348 review appointments.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The surgical service at Nuffield Health Tees Hospital consisted of one 30-bedded surgical ward for day case surgery and inpatients, pre-assessment clinic, an endoscopy unit and two operating theatres. The hospital treated both private and NHS patients and provided a range of surgery, including orthopaedic, ophthalmology, cosmetic, ENT, gynaecology, and general surgery for patients over the age of 18 years.

We visited the ward, theatres and endoscopy unit. We talked with 14 patients, 5 relatives and 41 staff, including nurses, allied healthcare professionals, resident medical officers (RMO), consultants, support staff and managers. We observed care and treatment and reviewed 20 clinical records. Prior to the inspection, we reviewed performance information about the hospital.

Summary of findings

Overall surgical services were safe, caring, effective, responsive and well-led. Incidents were reported and dealt with appropriately and themes and outcomes were disseminated to staff. Patient areas were clean and we saw staff wash their hands and use hand gel between patients. Bare below the elbow policies were mostly adhered to and there was enough personal protective equipment available to staff.

Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.

Medicine management arrangements were in place. There were reliable systems and practices to keep patients safe and safeguarded from abuse. Staff were able to recognise and respond to warning signs of rapid deterioration of a patient's health.

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. There were no unexpected deaths during 2013/14.

Nursing, medical and other healthcare professionals were caring and patients were positive about their care and experiences

There was effective communication and collaboration between multidisciplinary teams. Patients received care and treatment from competent staff. Patients were risk assessed appropriately and effective pain relief arrangements were in place.

Surgery

Service planning, delivery to meet the needs of people and access and flow arrangements were in place.

There were very few complaints arising from patient experiences in surgical services. Information about the hospital's complaints procedure was available for patients and their relatives. The service reviewed and acted on information about the quality of care that it received from complaints.

Staff were aware of the hospital's vision and there were good arrangements for monitoring the service at a local level. There was strong local leadership and quality care and patient experience was seen as all the staff's responsibility.

The hospital recognised the importance of patient and staff feedback and there were mechanisms to hear and respond to patient views. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Are surgery services safe?

Surgical services were safe. Incidents were reported and managed appropriately and themes and outcomes were disseminated to staff. The ward used the NHS safety thermometer audit tool for monitoring and analysing harm to patients and 'harm free' care. There was no patient harms reported for the hospital in the last 12 months. Patient areas were clean and infection prevention and control procedures were adhered to by the majority of staff.

Medicine management arrangements were in place. Patient records were detailed and stored securely. There were safeguarding policy and procedures in place to protect vulnerable adults and children from abuse and these were effectively followed by staff. There were processes in place for staff to recognise and respond to changing risks for patients, including responding to the warning signs of rapid deterioration of a patient's health. Staffing establishments and skill mix were reviewed regularly and levels increased to meet patient needs where required.

Incidents

Nursing staff were knowledgeable about the reporting process for incidents using the electronic hospital incident reporting system. Staff said they were encouraged to report all incidents.

The hospital reported 441 clinical incidents between July 2013 and June 2014. This equated to 29.17 incidents per 100 inpatient discharges. We discussed this with the hospital director because the figures were higher than would be expected. They told us the incidents related to all activity for the period which was 7179 (including day cases, inpatients and surgical outpatients) 70% of these were categorised as 'no harm' incidents. We reviewed the incidents and found clinical interventions such as catheterisation were being categorised as an incident. A manager told us catheterisations were no longer reported; this was confirmed by staff who said written instructions had been issued directing them not to report this procedure.

There were no serious incidents requiring investigation reported between July 2013 and June 2014.

Surgery

Staff told us they received feedback from incidents; written minutes of ward meetings confirmed this. We saw examples of where practice had been changed as a result of incident management. For example, implementing extra checks on patients for a particular procedure.

There were no 'never events' between May 2013 and July 2014 within the hospital. (Never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).

The hospital did not hold separate mortality and morbidity meetings however incidents and adverse events such as unplanned returns to theatre, transfers out and unplanned readmissions were discussed at the Medical Advisory Committee (MAC) and Clinical Governance Sub Committee. Minutes of MAC meetings January – July 2014 showed cases were presented and clinical aspects of care discussed.

Safety thermometer

The hospital used the NHS safety thermometer which is a local implementation tool for measuring, monitoring and analysing harm to patients and 'harm free' care. Monthly data was collected on pressure ulcers, falls, urinary tract infections, (for people with catheters), and blood clots (VTE).

There were two cases of hospital acquired VTE reported in 2013/14. Data showed all inpatients admitted between April 2013 and June 2014 were risk assessed for VTE. We saw completed VTE assessments.

A root cause analysis was carried out for both cases of VTE. In one case there were no recommendations. In the other there was the recommendation that fluid balance recording would be extended from the norm of 24 hours post-operatively to 48 hours in cases where there was a clinical indication of dehydration in the patient.

Safety thermometer information was not displayed in clinical areas however this information was seen in the acute service manager's office.

Cleanliness, infection control and hygiene

There were no cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) between April 2013 and June 2014.

All patients who attended the pre-assessment clinic prior to surgery were screened for MRSA and given appropriate treatment if their MRSA screening was found to be positive.

The hospital reported one case of abdominal surgical site infection in 2013/14. An audit of clinical records (July 2014) showed 100% of patients with surgical wounds were monitored at least daily for signs of surgical site infection.

The service carried out infection control audits; these included hand hygiene, environment, and surgical scrub hand technique and pre-operative, peri-operative and post-operative care. The ward and theatre areas achieved over 90% compliance against their infection control audits from January 2014 to October 2014.

Our observations during the inspection confirmed the majority of staff wore appropriate personal protective equipment (PPE) when required, and most staff adhered to 'bare below the elbow' guidance in line with national good hygiene practice. However, two consultants were observed wearing long-sleeved shirts and wristwatches whilst visiting patients in the ward area and a theatre staff member was observed washing down the operating table and handling a used instrument tray with no gloves.

All areas we visited had antibacterial gel dispensers at the entrances and by bedside areas. Appropriate signage was on display regarding hand washing for staff and visitors.

The ward area had facilities for isolating patients with an infectious disease.

There was a lead nurse for infection control who worked in this role 16 hours a week with support and advice being provided by a local NHS hospital. Link infection control nurses were identified for the ward and theatres. The matron was the designated hospital lead for infection control.

Staff were required to attend infection prevention and control training. Records showed 96% of staff had completed this training.

Quarterly infection control reports were presented to the hospital Medical Advisory Committee (MAC) and through the Infection, Prevention Control committee to the senior management team.

Surgery

The premises were visibly clean however some areas were carpeted and contained fabric chairs which could promote cross infection. The infection control lead told us these areas were being addressed by using washable vinyl surfaces.

Appropriate containers for disposing of clinical waste and sharps were available and in use.

We read the ward cleaning schedules and spoke with domestic staff who told us they had the correct equipment to carry out their jobs and were well supported by the domestic supervisor. There were two dedicated domestic staff in theatres and weekly cleaning schedules were completed and monitored by the theatre manager.

Environment and equipment

The ward area had single-use rooms each with suction equipment, piped oxygen, a nurse call bell and an emergency button.

We saw equipment on the ward had 'clean' labels on, which documented the time and date they were last cleaned.

We checked emergency equipment, including equipment for resuscitation, in the ward area and theatres and noted it was checked on a daily basis. Emergency equipment was kept in a prominent place on the ward, so it could be quickly accessed if needed.

We noted the endoscopy unit had a compliant bacterial and protein sampling history. Tracking of the decontamination cycle, personnel and patient association of each endoscope was completed using manual systems.

Staff working in theatres had sufficient theatre instrumentation to enable them to undertake their operating lists. For example, additional larger sized blood pressure cuffs had been purchased for patients with a higher body mass index.

In theatres, there were on-going maintenance checks at regular intervals to prevent the failure of equipment before it actually occurred and staff carried out their own equipment checks and logged the result. Records showed checks had been completed.

In-service and testing of electrical equipment (PAT) had been carried out in the ward and theatres. We found one out of date PAT test (March 2014) on a light source machine in the theatre suite and raised this with the manager who addressed this immediately.

Medicines

All areas we visited had appropriate lockable storage facilities for medicines.

Records showed drug fridge temperatures were checked daily.

We reviewed the medicine security checklist for the ward, theatre and pharmacy dated October 2014. This included an audit process for medicines management, and review of medication records. Records showed security of all medicines, including controlled drugs and prescription forms which provided access to medicines were managed appropriately.

The controlled drug register and other medication registers confirmed there was a checking process in place. Records showed regular monitoring and audit of the management and use of controlled drugs in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006. An audit carried out in September 2014 showed each criterion was met with 100% compliance.

Staff informed us they had access to an emergency stock of medication when pharmacy was closed. Prior to a patient discharge, a pharmacist or pharmacy technician met with the patient to review and explain take home medication.

We asked nursing staff about standards of checking medications before, during and after administration and found they understood the Nursing and Midwifery Council (NMC): Standards for Medicines Management. We observed nurses following NMC guidance, which confirmed what they had told us.

Records

The hospital had an integrated care record system that included key health questions, pre-assessment, risk assessment tools, anaesthetic room care, care during procedure, recovery care, post-operative care and discharge arrangements. All healthcare professionals, including consultants, nurses and the RMO documented care and treatment in the booklet.

Surgery

We reviewed 20 patient records. Most records were completed correctly but in two patient records, the date of their giving consent for treatment had not been recorded and for one patient, co-morbidity had not been recorded on the pre-assessment sheet.

Carer's assessments for patients with confusion or mild dementia were completed. This included information about family background, special life events, hygiene and mobility.

Records showed patients attending pre-assessment underwent a comprehensive health and social care assessment which included a holistic physical assessment and risk assessment for self-medication and discharge.

Health record keeping standards were monitored on a quarterly basis and actions taken. The July 2014 audit showed 91% compliance. Action had been taken in areas such as moving and handling assessments and recording of previous medical history.

Safeguarding

There were safeguarding policies and guidelines in place for the protection of vulnerable adults and children. All staff had access to a flowchart to aid with decision making and reporting safeguarding concerns. The hospital had a designated safeguarding lead who provided advice and training for staff and linked into the multi-agency safeguarding networks.

Nursing staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and had an awareness of the hospital safeguarding systems and processes.

Training data from January 2014 showed that 97% of nursing staff from the ward and 90% of staff from theatres and endoscopy had received level one safeguarding adults and children training.

Mandatory training

Nursing staff told us they had received mandatory training, which included infection control, moving and handling and health and safety and said they were given time to complete training.

Attendance rates for the ward showed as of 31st October 2014, compliance with mandatory training was 90% and in

theatres and endoscopy it was 87%. The hospital had processes in place to ensure all staff received mandatory training and where required additional training sessions were provided to fit around staff shift patterns.

Assessing and responding to patient risk

Patients were assessed in a nurse-led pre-assessment clinic prior to their surgery.

Further assessments of patients were conducted on admission; these included a pressure care risk assessment, patient handling, a risk assessment for VTE and a nutritional assessment. We reviewed medical records that confirmed pre-assessment and other risk assessments were conducted and completed accurately.

The hospital used an early warning tool called the Modified Early Warning Score System (MEWS). MEWS ensured standardisation of acute illness severity in hospitals. MEWS scores were incorporated in the integrated care record and we found these were comprehensively completed to ensure patients were being appropriately assessed for any signs of deterioration in their condition.

There was a comprehensive group policy for blood transfusions. Two units of O negative red cells were stored in the blood bank for emergency use. An electronic system (the Blood Audit Release System) (BARS) for patient identification and specimen labelling was used. An audit for safer blood transfusion (October 2014) showed compliance of 93% which was in line with the hospitals targets. Areas identified for improvement related to recording of post transfusion observations after the first or second unit of blood.

We observed the theatre team for an ophthalmology list undertaking the 'five steps to safer surgery' procedures (World Health Organization (WHO) checklist. All processes from the sign in before induction of anaesthesia to the sign out when the patient left theatre was completed correctly.

Information for January – March 2014 showed between 97% and 100% of the WHO checklist had been completed.

An observational audit of the WHO checklist carried out between January – March 2014 showed 99% compliance across the two theatres.

Records showed staff had received training in resuscitation including advanced life support in line with the

Surgery

Resuscitation Council Guidelines 2010. In theatres, a member of staff who held advanced life support certification was on duty at all times. The RMO also held advanced life support certification.

Unannounced visits by the resuscitation officer were conducted four times a year. Resuscitation scenarios were presented to staff to respond to during these visits, staff were regularly tested and their knowledge was reviewed in this area.

Staff said they discussed any patient risks or abnormal test results pre-operatively with consultant anaesthetists to decide whether surgery needed to be postponed or the patient transferred to the NHS as a higher risk case.

Nursing staffing

Nurse staffing levels were linked to the patient booking system and the ward used a minimum-staffing ratio of one registered nurse to eight patients (1:8) during the day and two registered nurses and one healthcare assistant at night. Nursing numbers were not assessed using an acuity tool; however the acute services manager informed us that, depending on the needs of patients, additional nursing staff could be rostered for any given shift. Staff confirmed they were able to cover shifts at short notice if required.

The majority of all theatre lists were staffed to recommended levels in line with the Association for Perioperative Practice guidelines.

Pre-assessment areas were staffed with two registered nurses and a healthcare assistant. Staffing in the area was adequate to meet patient need.

Managers and staff in theatres informed us they used their own staff to cover any shifts due to vacancies or sickness and agency staff were not used. This ensured the care patients received was consistent.

Nursing staff on the wards told us they had their own dedicated nurse bank and outside agency staff were not used.

Nursing handovers occurred three times a day. We observed a nursing handover during an afternoon shift. Individual patient's needs were discussed including pain relief and comfort.

Staff responded promptly to call bells and undertook their nursing duties in an unhurried manner. Data from a patient satisfaction survey (September 2014) showed 94% of patients who had used the call bell received the help they needed within two minutes.

Ideal and actual staffing numbers were not displayed on the ward.

Surgical staffing

All patients were admitted under the care of a named consultant. Consultants visited and reviewed their patients on a daily basis. Out of hours they were available to be contacted by the RMO. Staff and the RMO we spoke with raised no concerns about the support they received from consultants or their availability.

The hospital employed two RMO's who lived on-site while they were on duty and worked a seven day rota. There was 24-hour medical cover by the RMO's. Contingency plans and an on call system were in place to obtain cover if the RMO had been called out during a significant portion of the night. Shifts could be covered by another RMO or the consultant anaesthetist would be called in an emergency.

Processes were in place for the handover of patients. The RMO received information about patients from nursing staff at each shift change and had face to face discussions with the RMO going off-duty. Consultants were responsible to arrange cover where necessary for their own patient group. The matron and senior management team would be notified in advance of cover arrangements.

Advanced scrub practitioners (ASP) were employed in theatres. Some ASP's were trained and employed by the hospital. ASP's who visited and worked for a particular consultant surgeon during a procedure were subject to formal documentary checks and sign-off by senior managers. This meant that ASP's competence, experience and skill was subject to formal checking procedures before they were allowed to practice.

Major incident awareness and training

The hospital had a major incident plan which identified roles and responsibilities of the senior management team and staff. Theatres had their own on-call rota to ensure adequate back up and cover was available to deal with emergencies or incidents. The hospital recognised the

Surgery

importance of external major incidents however as a private healthcare provider its capabilities fell outside the areas of services that would normally respond to an external major incident.

Staff told us they participated in training for emergency scenarios such as fire evacuation, loss of vital services and responding to a cardiac arrest.

The hospital was a member of the critical care network, which meant patients who may deteriorate and required a higher level of treatment and intervention could be transferred to a NHS hospital. A senior manager regularly attended the critical care network meetings. Medical and nursing staff told us they were able to manage a deteriorating patient within the recovery area in theatres. An anaesthetist and consultant would manage a deteriorating patient until the patient was transferred to an NHS facility.

Business continuity plans for surgery were in place. These included the risks specific to each clinical area and the actions and resources required to support a return to normal services.

Are surgery services effective?

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. There were no unexpected deaths in 2013/14.

There was effective communication and collaboration between multidisciplinary teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients. Patients received care and treatment from competent staff, patients were risk assessed appropriately and effective pain relief arrangements were in place.

Evidence-based care and treatment

Evidence based care and treatment was carried out in line with National Institute for Health and Care Excellence (NICE) guidelines, such as 'prostate cancer diagnosis and treatment; inadvertent post-operative hypothermia and radio ablation of soft palate (snoring).

There was monitoring in place to ensure NICE guidance had been implemented. For example, the head of clinical services undertook an audit of NICE guidance on patient temperature monitoring (NICE CG65). A monthly review of 10 sets of patient records showed improvements in recording compared to an audit in December 2013. Where discrepancies were found action plans were completed and monitored through the local integrated governance groups.

The hospital was participating in an audit to peer review the cosmetic service provision measures in line with the Professional Standards of Cosmetic Practice – Cosmetic Surgical Practice Working Party, Royal College of Surgeons (RCS Professional Standards). The hospital director told us the audit would be completed by mid-December 2014.

The hospital had an integrated care record for surgery in place that included a risk assessment for venous thromboembolism (VTE). We read care records which showed all patients had been assessed and treated against a national surgical VTE pathway.

Pain relief

An enhanced recovery pathway was in place for patients admitted for orthopaedic procedures. Patients who underwent surgery followed a pathway that had been developed to ensure patients were provided with defined pre-operative, peri-operative and post-operative analgesia, which meant early patient mobilisation, independence and earlier hospital discharge.

We reviewed a number of integrated care pathway records and saw pain relief for patients undergoing a variety of procedures was documented. Patients told us pain relief arrangements were in place.

The patient satisfaction survey (September 2014) showed 99% of patients said staff 'always' responded appropriately to any pain they were experiencing.

Nutrition and hydration

The Malnutrition Universal Screening Tool (MUST) was in place and documented within the integrated care pathway records. Records showed these had been completed accurately.

Nausea and vomiting was formally assessed using a scoring system and recorded. The patient records we reviewed confirmed this had been carried out.

Surgery

A variety of food was available that included, vegetarian options, gluten-free, lighter options and multi-cultural food choices. Patients said, "The food was very good", and "There was plenty of choice and the food was delicious".

The hospital did not directly employ dieticians but staff told us they could access advice when required.

Patient outcomes

The hospital reported 17 unplanned readmissions between April 2013 and June 2014, which was a rate of 0.92 per 100 inpatient discharges.

The proportion of unplanned readmissions within 29 days that occurred between January 2014 and March 2014 was similar to that expected.

There were no unexpected inpatient deaths between April 2013 and June 2014.

The hospital reported nine unplanned transfers of inpatients to another hospital between April 2013 and June 2014, which was a rate of 0.49 per 100 inpatient discharges.

The proportion of unplanned transfers to another hospital was tending towards worse than expected between January 2014 and March 2014. Cases of unplanned transfers were discussed at the clinical governance subcommittee meetings and the MAC. We looked at the outcomes of three transfers which indicated patients were safely discharged from the NHS hospital.

In the period July 2013 - June 2014, 6506 surgical procedures were undertaken. There were seven unplanned returns to theatre. ‘

The hospital outcomes for the Patient Reported Outcome Measures (PROMS)

2013 /14 (provisional) for hips and knees and groin hernia repair showed the percentage of patients that had improved for each procedure was better than those reported nationally.

Competent staff

Staff told us they were encouraged to undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role.

Staff received a formal annual appraisal and mid-term appraisal every six months. We reviewed an appraisal compliance audit that confirmed 100% of staff had undergone an annual appraisal.

Appraisals were linked to the hospital vision and values and the Nuffield Health group strategy. Staff told us their objectives were set at appraisal and learning needs and further training was discussed and planned.

There were pathways in place to care for patients with dementia however not all staff had received formal training in this area. The hospital was aware of this and had identified a dementia lead to take this work forward and introduce dementia awareness training for staff.

There were systems in place for the effective management of doctors which included an annual appraisal for the RMO's. We looked at a completed appraisal for the RMO which was based on the GMC guidance 'Good Medical Practice' and completed by a medically qualified appraiser.

All cosmetic surgeons were on the specialist register for cosmetic medicine and vetted through the medical advisory committee to ensure they had the competency and skills to undertake the procedure.

The Medical Advisory Committee Chair (MAC) provided mentoring for the RMOs where required.

Fitness to practice issues for consultants was assessed by the MAC and any competency issues discussed with the medical director from the employing NHS hospital.

Multidisciplinary working

Records showed details of specialist referrals, including those made to community nursing teams and occupational therapy services. The hospital employed its own physiotherapists and pharmacists. This meant that multidisciplinary team support was available if patients required it.

Effective team working between ward and theatre staff was observed; interactions, interventions and treatment were recorded.

Discharge letters were sent to the patient's general practitioner (GP) and a copy of the letter provided to the patient. We reviewed several discharge records and spoke with patients ready for discharge, which confirmed this.

Seven-day services

Surgery

A RMO was available and onsite 24 hours a day 365 days a year.

Consultants provided 24 hour on-call (off site) cover for their patients. If they were unavailable at any time they organised a consultant colleague with admitting rights to provide cover in their absence.

The hospital pharmacy was open Monday to Friday between the hours of 8:30am and 4:30pm. We were informed that advanced prescribing was in place for those patients who were discharged at weekends.

The hospital's radiology and physiotherapy services were available Monday to Thursday 8am to 8pm and 8am to 5pm on Fridays. There was an on-call arrangement at weekends.

Theatres were available 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday and available for any returns to theatre 24 hours seven days a week should the need arise.

Access to information

The integrated care pathway records contained all of the information staff needed to deliver effective care and treatment and included risk assessments, care plans and medical notes.

NHS medical notes were available to staff via a track and trace system and could be accessed quickly, which meant when patients moved between services, on-going care and treatment was shared.

There was evidence of clinical discharge information being provided to receiving healthcare professionals with a copy given to the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Records showed patients gave consent to treatment during the pre-assessment stage. The integrated care pathway contained several sections where consent had to be obtained for on-going treatment and care. We reviewed consent forms and found these were completed appropriately and in line with Department of Health Guidelines. Patients confirmed they had received sufficient information regarding the risks and benefits of surgery to enable them to make an informed choice.

Staff said they had not received recent training in the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DOLS). However the hospital had recently introduced a designated lead for MCA and DOLS and a programme was being developed to provide staff training sessions.

The hospital had a policy of not admitting patients with advanced dementia although patients with mild dementia could be admitted for surgery and their care planned so their individual needs were met. Pre-assessment information showed planning took place to accommodate patients with mild confusion. An MDT approach was undertaken which included family or carers. A room near to the nurse's station was provided and staffing levels increased if one to one care was required.

Are surgery services caring?

Nursing, medical and other healthcare professionals were caring. We observed staff interacting with patients in a respectful and considerate manner. Patients were positive about their care and experiences. They felt involved in the decisions about their care and treatment and records were completed sensitively.

Compassionate care

All the patients we spoke with told us they were very happy with the service they had received from the hospital.

One patient told us "there were enough staff on duty and they did not rush when giving treatment". Other patients told us staff were very quick to answer call bells and they were treated with dignity and respect. They gave examples of staff knocking on doors before entry and asking them how they liked to be addressed.

The friends and family test response rate for the hospital between July 2014 and October 2014 ranged between 30.5% and 51.7% and the monthly scores ranged from 87% to 100% of patients who would recommend the hospital to family and friends which was positive.

We saw patients were cared for in accordance with national same sex accommodation guidelines as each patient had their own single room.

Understanding and involvement of patients and those close to them

Surgery

Patients told us they were involved in their care. One patient said they were consulted about their care plan and had completed it with the nursing staff. Another patient said their normal medicine

interacted with pain relief medication so the staff had changed it at their request. Patients told us staff spoke to them about their care and treatment in a way they were able to understand.

Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers for the hospital to ensure they had adequate support on discharge.

For patients undergoing cosmetic procedures there was a pre procedure consultation which included discussions about realistic expectations of the surgery. This also involved a cooling off period of at least two weeks. Marketing literature we observed was honest and responsible.

The patient satisfaction survey for September 2014 showed 90% of patients said they were given explanations regarding the risk and benefits of their surgery against a hospital target of 84%.

Emotional support

Hospital visiting hours were 9am to 9pm, which meant patients could have access to their family and friends for support if they chose to do so. A patient told us they thought visiting hours at the hospital were "very flexible".

For patients who needed further emotional support, staff told us they had the time to offer reassurance when required. We reviewed care records for patients who needed extra support and spoke to staff regarding their care. Records confirmed extra support was available.

Staff were aware of a range of counselling services where patients could be signposted if required.

Pre-assessment staff gave examples of how they listened to patients and made a holistic assessment of patient's well-being and readiness for surgery. For example, staff told us of occasions when patients had postponed surgery for emotional reasons following discussions at pre-assessment.

Are surgery services responsive?

We found the service was responsive. Service planning, delivery to meet the needs of people and access and flow arrangements were in place.

There were very few complaints arising from patient experiences in surgical services. Information about the hospital's complaints procedure was available for patients and their relatives. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

The hospital had a contract with NHS providers for treatments such as general surgery, ophthalmology, orthopaedics and endoscopy. The contract set out various exclusions, which included not allowing the hospital to admit patients whose pre-existing medical condition was not deemed stable. It also excluded the hospital from admitting patients in certain categories such as those whose body mass index (BMI) was over 40.

All admissions for surgery were planned in advance and included private patients and NHS patients. There was no differentiation between NHS or private patients.

Access and flow

Access and flow was linked to the hospital's booking system and most surgery was elective other than those patients who had to return to theatre unplanned.

We found that theatre staff had an on-call arrangement to manage any unexpected returns to theatre. This arrangement included night and weekend cover.

Patients undergoing cataract surgery received staggered appointment times to reduce patients fasting pre-operatively for long periods before their surgery.

Healthcare assistants had received extra training to allow them to admit and discharge patients, although a registered nurse remained ultimately responsible for the patient's care. This meant patients had timely access to care and treatment and action had been taken to minimise the time they had to wait.

Action was being taken to improve pre-assessment times for patients to avoid any delay in surgery. The service

Surgery

manager was addressing this by running extra clinics to bring forward appointments. There was a target for all patients to receive their pre-assessment two weeks prior to admission by the end of December 2014.

Records showed there were 29 theatre cancellations between January and June 2014. The majority of these related to cancelled surgery on admission due to clinical reasons.

Meeting people's individual needs

Staff informed us patient's individual needs were assessed at pre-assessment clinic and patients who required extra care, such as those living with mild dementia, would be assisted by ensuring there was extra staff available and arrangements were made for their carers to help if required.

Discharge planning commenced at the pre-assessment stage. Planning for discharge continued during admission with specialists such as social services being identified and arranged for while the patient was in the hospital.

Staff had access to interpreter services although some patients chose relatives to translate for them.

Learning from complaints and concerns

Complaints were handled in line with hospital policy. Information was given to patients about how to make a comment, compliment or complaint.

The matron oversaw complaint investigations and the hospital director had responsibility for all responses to complainants. Complaints were at a low level, there were 12 complaints from April 2013 to July 2014.

The hospital had a patient advocate who carried out patient interviews and acted on any areas of concern. Daily senior staff ward rounds also took place.

The quality assurance review and action plan (September 2014) demonstrated 100% compliance with the complaints procedure, which included responding to complaints within set timescales and advising complainants on how to escalate concerns.

Arrangements were in place for staff to learn from complaints or patient experiences in order to improve care.

For example, pre-assessment clinic had introduced a voicemail system which was activated during clinic times to avoid telephones ringing and disrupting clinics and to enable patients to leave messages.

Are surgery services well-led?

Surgery was well-led. Staff were aware of the hospital's vision and there were good arrangements for monitoring the service at local level. There was strong local leadership of the service and quality care and patient experience was seen as all the staff's responsibility.

The hospital recognised the importance of patient and staff feedback and there were mechanisms to hear and respond to patient views. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Vision and strategy for this service

A caring and passionate service was the main focus of the hospital's values. Staff could tell us what the vision and strategy for the service was and we saw the purpose, vision, mission, values and beliefs document displayed throughout patient and staff areas.

Staff were proud of the job they did and felt empowered to deliver a caring service by being supported by strong hospital leadership.

Governance, risk management and quality measurement

There was a proactive approach to monitoring and measuring various aspects of quality and safety in surgical services. The clinical services manager and matron carried out regular audits which were aligned to the five domains of safety, caring, effectiveness, responsiveness and well-led. The quality assurance report for 2014 showed good compliance against a variety of indicators. Where improvements were required staff roles and responsibilities were identified to carry out the actions and disseminate learning to staff. A cosmetic surgeon was the identified clinical governance lead.

Theatres, endoscopy and the ward were represented at hospital governance meetings and this flowed through to the Medical Advisory Committee (MAC). Meetings for October 2014 showed areas discussed included departmental feedback on operational issues, risks, staffing and complaints.

Surgery

External Commissioning for Quality and Innovation (CQUIN) framework measures had been agreed for 2013/14. The measures were negotiated to improve local quality and were in line with the strategic quality aims of the hospital. Measures included VTE risk assessments, completion of the NHS Safety Thermometer, implementation of the WHO checklist, completion of early warning scores, intra-operative fluids and patient temperature checks. CQUIN data showed there were no hospital outliers against these targets.

A hospital risk register was in place and managed at group, divisional and individual facility level and formally reviewed at the relevant committees and boards.

A Board Risk Assurance Report was presented to the Board of Governors on a quarterly basis and provided a description of the top strategic risks in the organisation. This ensured the Board had visibility of current and emerging risks from across the services.

100% of the hospital's staff had their registration status verified, including doctors, theatre staff and nurses.

Effective processes were in place for granting practicing privileges to enable doctors to work at the hospital. Approval to grant, restrict or withdraw practicing privileges was considered by the MAC with involvement of the hospital director. Records demonstrated doctors had to have the relevant clinical experience to practice in an independent hospital, personal audit data and patient outcome measures and references from peer practitioners.

Procedures were in place to ensure surgeons had an appropriate level of valid professional indemnity insurance. We looked at a sample of five staff files and found indemnity arrangements were appropriate and valid.

The hospital used an electronic system which monitored the current status of practicing privileges, GMC registration and indemnity arrangements. Administrative staff reviewed the information on a daily basis and sent reminders to doctors whose registration had lapsed.

The senior management team (SMT) had responsibility to review performance against quality indicators on a monthly basis and completed actions were signed off by the SMT. Monitoring was carried out through the quality assurance review process and progress against improvements was feedback through the Nuffield Health governance structures to the Board.

There was evidence of national learning from other hospitals in the Nuffield Group. For example, a manager and matron quarterly quality and safety governance update 'Point of care to Board to point of care' was distributed to hospitals. We saw national feedback from a never event relating to an incorrect lens implant had led to changes with the introduction of a new cataract WHO safety checklist.

Leadership of service

There was strong local leadership of the service. The acute services manager also worked clinically and was seen by staff on a daily basis.

We reviewed several patient records and noted the acute services manager visited every patient daily and made entries into the notes.

There was an interim matron in post and all the staff told us they felt well supported by their managers and peers.

Staff said they could report any concerns they had about the service or practice and said it would be listened to and addressed.

Consultants felt there was a good working relationship with hospital management team and the staff. The MAC chair said they were fully engaged with the SMT and involved with corporate and clinical governance issues.

Culture within the service

Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and all of the staff groups' responsibility.

Openness and transparency was the expectation and was encouraged at all levels. Staff we spoke with told us they worked well together and there was obvious respect for others across disciplines.

The hospital was developing procedures and staff training to incorporate the new regulations relating to duty of candour. Being open policies were already in use and an open culture was observed for reporting and responding to incidents and complaints.

An employee assist programme was available for staff to access counselling or occupational health services. A 24 hour helpline was also available for staff to contact anonymously to discuss concerns.

Surgery

The MAC chair told us there was a very positive culture for reporting incidents and any staff were encouraged to report any deviations to care however trivial. This enabled a full review of trends and near misses.

As at September 2014 staff turnover was 8.4% and short term sickness 1.5%.

Public and staff engagement

The acute services manager or a designated deputy gathered patient views and experiences, by telephoning every patient after they had been discharged from the hospital. This was a key driver for how services were provided as results were logged and acted on. For example, the hospital was undergoing a refurbishment programme in response to patient feedback.

We reviewed the hospital's local level leadership 'MOT' results (September 2014), which gathered staff views on a variety of topics such as patient care, customer experience and job satisfaction. The results were discussed at team meetings and we read the theatre team meeting minutes (1st October 2014) that confirmed this. Data showed 99% of staff would recommend the hospital to family and friends.

A consultant opinion survey 2013 showed the majority of doctors strongly agreed or agreed in areas such as flexibility of consulting and operating times, appropriate staffing levels and competency of staff.

Innovation, improvement and sustainability

Staff said they felt encouraged to learn and improve. The appraisal system was linked to the hospital's strategy. For example, staff objectives were set to encourage continuous learning, improvement and to focus on quality patient care.

There were systems in place to improve performance which included the collection of national data, audit and learning from complaints and incidents. A number of action plans had been developed and these were monitored on a regular basis. The hospital director told us further work was taking place to improve data collection to support external benchmarking.

Changes had been made to improve the environment and provision of extra clinic appointments to reduce delays for patients.

There were effective processes to ensure efficiency savings were achieved without impacting on the quality of patient care. The hospital's negotiations with key suppliers of equipment had resulted in a reduction of loan and hire costs.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Nuffield Health Tees Hospital has a busy outpatient and radiology department hosting a number of different specialities including orthopaedics, plastic surgery, ophthalmology, cosmetic surgery, gastroenterology, ENT, gynaecology, general surgery, vascular surgery, dermatology, rheumatology and oral surgery. The MRI scanning service at the hospital is provided and managed by an external provider with a service level agreement and contract to provide a mobile MRI service and staff for two full days each week.

From January 2014 to September 2014 the hospital outpatient department saw 21,467 patients. Of these, 5,192 were new appointments and 13,348 were review appointments. The hospital saw 13,663 NHS appointments and 7,813 private patient appointments.

During the inspection we visited the outpatient department, physiotherapy and radiology.

We spoke with ten patients, three nurses, one consultant, five administrative staff, three medical laboratory assistants, one physiotherapist, three managers, two radiographers, two healthcare assistants and two pharmacy staff. We observed the outpatient environment, checked equipment and looked at patient information. We also reviewed seven patient medical records as well as performance information from the hospital.

Summary of findings

Overall, the care and treatment received by patients using the outpatient department was safe, effective, caring, responsive and well-led. Patients were happy with the care they received and found the service to be caring and compassionate.

Staff were well trained and supported and worked within nationally agreed guidance to ensure patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm, because policies and procedures were in place to ensure this was managed appropriately.

Patients were given follow-up appointments when they should receive them. Staff were listened to, and patients were engaged with and their opinions actively sought.

On the whole, the services offered were delivered in an innovative way to respond to patients' needs and ensure departments worked effectively and efficiently.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Care and treatment delivered by the outpatient service was safe. Incidents were reported, investigated and lessons learned. The cleanliness and hygiene in the department was within acceptable standards however not all staff adhered to the use of personal protective equipment. There was sufficient and well maintained equipment to ensure patients received the treatment they needed in a safe way.

Staff were aware of the policies to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. There were sufficient well trained and competent nursing and medical staff within the department to ensure patients were treated safely. Staff told us they were aware of their responsibilities in the light of major incidents.

Patients were, protected from receiving unsafe care, because medical records were available for outpatient clinics.

Incidents

Between July 2013 and June 2014 outpatients, pathology and radiology reported 42 incidents. Of the incidents, 27 were graded as no harm, 14 low harm and one moderate harm. The main theme identified related to IT problems.

All staff were aware of how to follow the hospital's policies and procedures for reporting incidents. General incidents were reported and investigated in line with trust policies. We looked at 20 reported incidents within the radiology department for July to September 2014 and saw these were managed in accordance with the incident management policies. We saw the recommended actions and lessons learned from recent incidents had been completed in accordance with the risk management outcomes. For example, we saw one matter had been escalated to the appropriate committee for action due to a recurring reporting problem.

In radiology, incident numbers had increased over the most recent two-month period due to IT issues. Fourteen out of a total of seventeen reported incidents were due to the instability of an old IT system and the implementation of a

new system. The radiology manager told us no significant harm was incurred in any incident. Two incidents caused patient examinations to be delayed; the worst case was for 15 minutes.

Managers within outpatients and radiology told us they provided staff with verbal feedback from incidents at team meetings. Staff confirmed the manager fed back the learning from incidents and discussed how they could do things differently to improve.

Cleanliness, infection control and hygiene

Clinical and non-clinical areas in outpatients and diagnostic imaging appeared clean and tidy, with equipment stored appropriately.

We saw staff adhering to the hospital's bare below the elbows policy.

Staff wore protective aprons and most wore gloves when required and regularly used hand gel between patients. However, the team of three medical laboratory assistants reported they did not routinely wear gloves for blood sampling. This was not in line with hospital policy which stated that gloves should be worn for this procedure. Staff had performed their own risk assessment regarding this and highlighted that gloves interfered with palpation and dexterity, however there was not a formal risk assessment regarding this practice. We discussed this with the senior management team who said they would review procedures for this area. Staff within other areas did wear gloves and other personal protective equipment (PPE) in adherence to hospital policy.

Hand washing signage was clearly displayed and sufficient supplies of hand gel, hand soap and paper towels were available throughout the department.

The outpatient and diagnostic imaging departments were part of the hospital wide infection control audits and spot checks which monitored compliance with key hospital policies such as hand hygiene. Outpatients and diagnostic imaging demonstrated 100% compliance with infection control procedures during 2014.

Cleaning audits were displayed and records of cleaning schedules were checked, signed and up to date.

Outpatients and diagnostic imaging

Staff in pathology were responsible for the storage of samples and blood products and were aware of the need to maintain a cold chain when transporting blood products. Contingency plans were in place for transfer of blood products should refrigeration problems arise.

Environment and equipment

The environment in outpatient areas appeared uncluttered, and well maintained.

Patient waiting areas were tidy with sufficient comfortable seating for patients visiting the department. There was access to drinks and books and magazines for patients who were waiting.

There were toilet facilities available for patients however there was only one disabled access toilet within the hospital. The hospital had identified this on the risk register and was looking at possible solutions.

Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments.

Staff had sufficient equipment to meet the needs of patients. They told us when a need for equipment such as a light in the treatment room and a piece of more specialist equipment in radiology had been made, this had been supplied.

We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained. Portable appliance testing (PAT) was up to date.

Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment. X-ray equipment maintenance contracts were checked and records showed all schedules were up to date. Staff told us requests for service and repairs were met quickly and effectively by all contractors.

Ionising Radiation (medical exposure) Regulations IR (ME) R and Radiological Protection Centre (RPC) survey reports from 13 December 2013 showed that all equipment met national requirements for safety. Checks were up to date and records showed the safety levels had been consistently good over previous years.

There was a service level agreement and contract in place with an external provider for the MRI scanning service and an agreement with the local NHS Trust MRI unit for support in case of emergency or failure of the MRI equipment or process.

Records showed resuscitation equipment and defibrillation machines were checked daily in the outpatient department.

Physiotherapy had a fully equipped gym for rehabilitation and therapeutic regimes. The waiting area had sufficient clean and comfortable seating and a water cooler. A bell had been provided following a suggestion from a patient who had waited for ten minutes to be seen during an evening clinic.

The ultrasound machine had recently been replaced with a new model. The radiology manager told us new or replacement equipment was provided by the hospital when a comprehensive business plan was presented.

Medicines

Medicines including local anaesthetic and contrast media were supplied and audited by the pharmacist.

Safe temperatures for fridges were recorded and a log of medication contents maintained.

The medicines cabinet was kept locked at all times and the key was kept in the manager's office which was also locked when unoccupied.

Outpatients only used one patient group directive (PGD) for the influenza vaccine they offered to patients and staff. This had been updated in 2014.

Records

At the time of inspection we saw patient personal information and medical records were managed safely and securely.

We looked at the medical records of seven patients attending outpatient clinics. We found these were of a good standard. They contained sufficient up to date information about patients including referral letters, medical and nursing notes, operation and anaesthetic records and discharge documentation.

Discharge and clinic letters were written and sent quickly. The longest time we saw between clinic and letter being sent was three days.

Staff we spoke with in outpatients, radiology and physiotherapy could not recall an instance where medical records had not been available for a clinic, or where a patient could not be seen because their records were not available.

Outpatients and diagnostic imaging

Some of the departments were using electronic records. For example, the physiotherapy department had a fully auditable electronic records system and all x-ray images were processed and stored digitally. Staff in both departments told us about alternative storage and retrieval methods they used when digital systems failed. There were clear and effective business continuity plans within the department.

Patient records in pathology were limited to patient request forms which were completed and handled appropriately. An electronic barcode system was used to identify the staff member taking blood samples, to identify patients and print labels for forms and sample tubes. Staff reported the system had reduced the number of errors and omissions on sample labels cutting down on time spent on chasing information and the need for samples to be repeated.

Record keeping had recently been audited across the physiotherapy, radiology and pathology departments. The July 2014 audit showed 91% compliance. The audits had identified actions to make improvements. Action plans were in place to ensure improvements were made. Areas for improvement, included recording of outcomes at every visit. We looked at ten x-ray request forms and found all had been completed clearly and all patient information was presented. Patient signatures were present on all forms. Outcomes had been completed in all cases.

Safeguarding

The hospital had safeguarding policies and guidance in place for both children and adults.

Safeguarding training was mandatory for all staff. The training rate was 92% for vulnerable adults training and 90% for safeguarding children.

All staff we spoke with were aware of safeguarding policies and guidance and could describe how to report and escalate a safeguarding issue.

All staff had access to a simple flowchart to aid with decision making and reporting concerns regarding vulnerable adults.

Mandatory training

Staff reported mandatory training was delivered by a combination of face to face training and eLearning. They

reported both they and their line manager received automatic electronic alerts from the human resources team when training was due. All staff were given sufficient time to complete mandatory training.

Training records showed the hospital was achieving expected training levels in Fire Safety (98%), Health and Safety (98%), Infection prevention (97%), Manual Handling (97%), Information Governance (91%), vulnerable adults (92%) and safeguarding children (90%). There were two training modules where the hospital was not meeting expected training levels. These were Basic Life Support (Including ILS) (68%) and Safer Blood transfusions (25%). The hospital had arranged for staff to attend additional sessions in these areas.

Medical staff completed mandatory training at their main employing NHS trust. There were assurance systems in place to make sure that medical staff were up to date with mandatory training.

Assessing and responding to patient risk

There was a process in place for managing patients who were deteriorating. This included involving the patient's consultant, contacting the resident medical officer and transferring the patient to the Accident and Emergency department of the local NHS hospital. Staff were aware of their roles and responsibilities when patients deteriorated.

There were emergency assistance call bells in all patient areas including consultation rooms, treatment rooms and x-ray. Staff confirmed when used they were answered immediately.

We observed staff responding to a risk during our inspection when a patient was brought from the ward after concerns had been identified. Radiology was involved and the patient was rescheduled to attend theatre the same afternoon to rectify the problem.

Nursing staffing

The outpatient department had a dedicated team of registered nurses, healthcare assistants, medical laboratory assistants, physiotherapists, radiologists, receptionists and administration staff.

Outpatients and diagnostic imaging

Staffing levels were based on the number of patients expected to attend and number, type and complexity of clinics to be held however there was no specific acuity tool used. The department was able to use staff flexibly to meet patient needs.

Staff and patients we spoke with, and our observations confirmed there was enough staff available to meet patient's needs.

There were no vacancies within the nursing and health care assistant staff in the outpatient department at the time of inspection. A total of 2.6 WTE nurses and 1.6 HCA were employed. Bank staff were used in clinics on occasion to cover holidays, sickness and expected busy times. The hospital used its own bank staff that worked at the hospital regularly and were familiar with the organisation, policies and procedures.

The radiology department staffing consisted of one radiology manager (radiographer), five part time radiographers (WTE 4) and two health care assistants. There was one radiographer (30 hours) on long term sick leave. The staff were working extra hours with bank staff to fill any remaining gaps. However, another radiographer (30 hours) was due to go on long term sick leave later this month. This would leave the department with only 66% of its staffing requirement. The manager had made three attempts to fill gaps using agency staff but this had been unsuccessful. Another agency had identified a radiographer who was due to start induction the week following the inspection.

There were systems and processes in place to request additional temporary staffing and the service used temporary nursing, physiotherapy and radiography staff when shortages were identified.

Medical staffing

The hospital employed two resident medical officers who covered the hospital 24 hours a day seven days a week. They were present to manage emergency situations.

There were 135 Consultant doctors and dentists employed by surrounding NHS trusts that had practicing privileges to run clinics, carry out treatment and procedures and operate at this hospital.

A consultant opinion survey 2013 showed the hospital was sufficiently flexible to accommodate doctors preferred consulting times in outpatients.

Major incident awareness and training

There was a hospital major incident policy and staff were aware of contingency plans should major incidents occur. As an independent provider the Nuffield Health Tees Hospital would not routinely become involved in major incidents external to the organisation.

Radiology staff had taken part in a major incident scenario in September 2014. They followed the correct procedures and discussed the outcomes and lessons learned as a team. Findings were documented and shared with the hospital risk governance team for wider learning.

Are outpatients and diagnostic imaging services effective?

Services provided by the outpatient department were effective. Care and treatment was evidence based and patient outcomes were measured and within acceptable limits. Staff in the department were competent, and there was evidence of multidisciplinary working. Although the service did not operate a full seven day service, the outpatient department had extended opening hours and support services such as physiotherapy and radiology were in place 24 hours a day, seven days a week.

Evidence-based care and treatment

Departments were adhering to local policies and procedures. Staff were aware of how policies and procedures had an impact on patient care. For example, physiotherapy was following NICE guidance in relation to acupuncture and consultant led protocols regarding post-operative physiotherapy and rehabilitation.

Hospital and national Nuffield Health policies were adhered to in accordance with Radiology Protection Association (RPA) and Ionising Radiation (Medical Exposure) Regulations IR (ME) R guidance and requirements.

An audit was carried out on radiology staff equipment competencies. This included new equipment used in the department and all staff had shown 100% compliance to date. Completion of radiology request forms was audited and where compliance was less than optimal a learning tool was developed for radiographers to check their own practice. This audit was due to be repeated in December 2014.

Outpatients and diagnostic imaging

Staff from the outpatient department, physiotherapy and radiology told us they took part in local audits. For example, infection control, documentation and film reporting. All of these audits either demonstrated compliance or identified action to take to improve practice, for example the physiotherapy department had identified areas for improvement in record keeping and had an action plan in place to improve standards. Safety alerts were received by the department managers and all relevant alerts were emailed to all staff, displayed in the staff office and discussed at team meetings.

Physiotherapists told us how they peer reviewed cases and undertook reflective discussion around what went well and what could have been improved or what they may have done differently. Reflection on practice had informed changes to exercise classes for patients suffering from back pain as well as physiotherapists considering a wider range of treatments or interventions for individual patients.

Pain relief

There was a process in place to enable patients attending the outpatient department to access pain medication. Pain medication was dispensed via a personalised prescription by the pharmacy. At times when the pharmacy was closed staff were able to access medication.

The radiology department kept a supply of relevant and appropriate medication for the procedures carried out including local anaesthetic during ultrasound-guided biopsy procedures. This was stored safely and securely in the medicines cabinet and overseen by pharmacy.

Patient outcomes

From January 2014 to September 2014 the hospital outpatient department saw 21,467 patients. Of these, 5,192 were new appointments and 13,348 were review appointments. The hospital saw 13,663 NHS appointments and 7,813 private patient appointments.

Patient outcomes in physiotherapy were monitored by well recognised outcome measures such as range of movement, pain scores and quality of life measures to establish effectiveness of treatment. Distances walked and numbers of repetitions were also used as measures of improvement where appropriate.

All images were quality checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity.

Competent staff

Managers told us formal arrangements were in place for induction of new staff and all staff, including bank and agency staff, completed full local induction and training before commencing their role. We saw induction records completed and a full pack prepared for a new agency worker due to start in the department the following week.

Managers and staff told us performance and practice was continually assessed through appraisal and mid-year reviews. Reviews were carried out twice a year. Staff we spoke with confirmed they received regular appraisals and mid-year reviews. The appraisal rate for outpatient staff was 100%.

All qualified radiographers completed equipment competencies annually. Continual professional development was planned by the manager on an annual basis to ensure all statutory and topical subjects were covered and staff who had attended training were required to present and cascade their knowledge to the team at monthly staff meetings. Minutes of meetings showed evidence of presentations being given, such as a member of staff cascading training they had received about small bone imaging.

Staff confirmed they were encouraged to consider and undertake continuous professional development and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. We saw all staff training and competency records were completed and retained safely and securely in staff training files.

Medical revalidation was carried out at the main employing NHS trust for consultants with practicing privileges and by the responsible officer for the two RMOs who worked at the hospital. There was a process in place to ensure all consultants were up to date with the revalidation process.

Copies of all staff registration were shown to us along with a log of registration renewal dates. All registrations were up to date.

Multidisciplinary working

A range of clinical and non-clinical staff worked within the outpatients department and told us they all worked well together as a team.

Staff were observed working in partnership with a range of staff from other teams and disciplines including

Outpatients and diagnostic imaging

radiographers, physiotherapists, nurses, booking staff, and consultant surgeons. Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.

There were clear agreed protocols for staff to follow and where patient care deviated outside of these, nursing, radiology, laboratory and physiotherapy staff told us they were able to easily access consultants and specialist staff such as the hospital lead for safeguarding to discuss required interventions.

Seven-day services

The main outpatient service operated a six day week Monday to Thursday 8am to 8pm, Friday 8am to 5pm service and Saturday 9am until 1pm

Radiographer cover was provided 24 hours a day and seven days per week with full departmental cover between the hours of 8am to 8pm Mondays to Thursdays; 8am to 5pm on Fridays; 8am to 1pm on Saturdays to meet the needs of outpatients and theatres. Night and weekend on-call was organised by a rota system.

Physiotherapy offered extended hours until 8pm Monday to Thursday and a 24-hour, seven-day on call service to inpatients.

Phlebotomy services were available from 9am to 5pm for people to have their blood samples taken. We saw the full on-call list for the current week and staff confirmed it was correct and up to date.

Access to information

All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.

Staff were able to access patient information such as x-rays, medical records and physiotherapy records appropriately through electronic and paper records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Senior staff reported that within the outpatients department implied consent was obtained from the patient before any care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and basic physiological signs. Staff reported if consent could not be safely obtained or the

patient lacked capacity to consent, they would contact the hospital safeguarding lead for advice. There was a process in place for staff to follow when patients were not able to give consent because they had fluctuating capacity.

We spoke with a number of staff about their understanding of consent, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). Although staff had an understanding of consent they had limited understanding of the MCA and DOLS and were awaiting training. The hospital was in the process of planning training for all staff.

Radiographers obtained written consent from every patient before commencing any procedure.

Are outpatients and diagnostic imaging services caring?

During the inspection we saw and were told by patients that staff in the outpatient department, physiotherapy and radiology were caring and compassionate. Patients and relatives commented positively about the care provided from all of the outpatient and diagnostic imaging staff.

People were treated courteously and respectfully and their privacy was maintained. Services were in place to emotionally support patients. Patients were kept up to date with and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions or treatment.

Compassionate care

The patients we spoke with in the outpatient clinics spoke highly of the care and treatment they received. There were no negative comments about the compassionate and caring aspects of the service.

During our inspection we saw patients being treated respectfully by all staff. We also saw occasions when staff noticed that patients were nervous and reassured them.

We saw patient's privacy was respected and they were addressed and treated respectfully by all disciplines of staff. Staff were observed to knock on doors before entering.

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Curtains were drawn and doors closed when patients were in treatment areas and consulting rooms. The environment in the outpatients department allowed for confidential conversations.

Staff made sure patients were kept up to date with waiting times in clinics; patients told us this meant they were able to take comfort breaks if they needed to. Patients also told us they had been offered alternative appointments when clinic waiting times became long or if they were unable to stay.

We saw patients and staff had a good rapport and staff put patients at ease. Some patients were regular attenders and knew the staff well. New patients also confirmed they were put at ease and felt staff were caring towards them.

We spoke to two patients who gave very positive accounts of their experiences with staff and the processes followed. One patient told us this was his second operation at the hospital and he had found everyone to be polite, friendly, caring and very quick and efficient.

Two patients told us they had received excellent care from radiographers during their visit to the department.

Flexibility was offered around outpatient appointments and where possible aligned to other investigations for example, phlebotomy appointments were offered to coincide with a visit to x-ray.

Understanding and involvement of patients and those close to them

We observed staff spending time to explain procedures to patients before gaining written consent. For example, radiographers were seen and heard to explain to patients what to expect when procedures were carried out. They explained what each procedure would entail and they gave instructions on what the patient needed to do, including undressing and wearing a gown, where to wait and how long the whole visit should take.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.

All of the patients we spoke with told us they fully understood why they were attending the hospital and had

been involved in discussions about the care and treatment they could have. They all confirmed they were given time to make decisions and staff had made sure they understood the treatment options available to them.

Emotional support

We saw staff spend time talking to patients and showing empathy and encouragement to complete aspects of therapy.

Staff were aware of the emotional impact of pain on patient well-being and this was an integral part of quality of life measures used in physiotherapy to assess and evaluate clinical improvements and effectiveness of treatment.

Staff were aware of a range of counselling services where patients could be signposted should the need arise. This was particularly pertinent for patients undergoing cosmetic surgery.

Staff were able to give examples of when they had talked to worried patients, for example when a patient had complained of discomfort in his recently operated hip to help him to remain calm whilst still carrying out imaging. The staff member stayed with the patient and reassured them until the consultant was available to explain the x-ray findings.

We were told all ultrasound patients were always chaperoned (usually by a health care assistant) during their procedure.

Are outpatients and diagnostic imaging services responsive?

Outpatient services were responsive to needs of patients. Patients were able to be seen quickly for urgent appointments, if required and clinics were only rarely cancelled at short notice.

Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability, or those whose first language was not English.

Systems were in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

Outpatients and diagnostic imaging

Staff and patients told us clinics seldom ran late however there was no data collected by the hospital about this. When clinics were running late, or patients had waited for more than 20 minutes patients were offered the opportunity to reschedule their appointment if they wished.

Clinics tended to run in a predictable pattern and the busier time periods were staffed accordingly.

Staff told us clinics were only rarely cancelled with short notice, but that clinics were occasionally cancelled with notice, to fit in with the NHS commitments of consultants. Between January 2014 and September 2014 79 (4.2%) of NHS clinics had been cancelled. Reasons included; administrative errors (24), consultant away (5), consultant on call (8), consultant annual leave (5).

Physiotherapy, radiology and outpatients offered late appointments four days a week to meet the needs of working people.

Radiology services were planned around outpatient and theatre activity including extended hours in the evenings and on Saturday mornings.

Phlebotomy staff routinely asked patients if they were attending the hospital for other appointments and scheduled attendance at their clinic when patients would be attending for other tests such as x-rays.

Access and flow

The waiting time for patients varied depending upon the specialty they were referred to. Patients waiting for a first appointment for cataract surgery for example would expect to receive an

appointment for 13 days' time, for a hernia repair, ten days, an orthopaedic appointment, between 12 and 41 days depending upon which joint was involved and for plastic surgery, 13 days' time.

The hospital collected limited data about 'Did not attend' (DNA) rates and only collected information relating to NHS patients. The DNA rate for new appointments of NHS patients was 1.2%. The DNA rate for NHS review appointment was 1.3%.

Patients were observed to be seen on time in the majority of cases however the hospital did not collect information about how long patients were waiting to be seen once they arrived.

Most patients who used the hospital, whether as a private patient or an NHS patient were referred by their GP.

Self-funding patients could access physiotherapy by self-referral, either by calling the department directly or by arrangement through the Nuffield Health central booking system. Patients who had self-referred to physiotherapy underwent a telephone assessment prior to being seen in the department.

The hospital ran NHS clinics and clinics for private patients. There was capacity within the service to see patients urgently if necessary.

Radiologists and surgeon's workflow statistics were recorded and comparisons made against national guidelines and previous year's results to aid planning and risk management.

Two patients told us the main reason they were using this hospital was for peace of mind and stability because the local NHS Trust hospitals could not offer such a quick and efficient service.

Meeting people's individual needs

Staff told us they were able to access interpreting and translation services if they needed to. One manager told us they had requested an interpreter a few months ago and they had arrived with the patient with only a week's notice. Some staff however told us that occasionally they used family members to translate, which was against best practice.

A range of information leaflets were available, which provided patients with details about their clinical condition and treatment or surgical intervention. We saw staff used these leaflets as supportive literature to reinforce their physiotherapy treatment and exercise regimes.

Some patient information leaflets were available in large print for patients with visual impairment. Patient information was not available in alternative languages but staff explained they would ensure the patient fully understood what they needed to, before they left the department.

Staff told us when patients with learning disabilities or dementia attended the departments; they allowed carers to remain with the patient if this was what the patient

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wanted. They also ensured that patients were seen quickly to minimise the possibility of distress to them. Staff told us they would use a common sense approach and dealt with each person and situation individually.

Information signage was adequate within outpatients and diagnostic imaging and patients appeared to be able to make their way around both departments easily.

Learning from complaints and concerns

The hospital reported four formal complaints between April 2014 and July 2014 for outpatient areas.

Staff described how they would resolve patient's concerns informally in the first instance, but would escalate to senior staff if necessary.

Staff were aware of the formal complaints process and policy and the mechanisms for reporting, investigation and feedback to departments.

Complaints and comments were reviewed and discussed by teams at monthly staff meetings. We saw minutes of meetings which reflected this.

Are outpatients and diagnostic imaging services well-led?

The outpatient department was well-led. Staff and managers had a vision for the future of the department and were aware of the risks and challenges faced by the department. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed. The department supported staff who wanted to be innovative and try new services and treatments.

The hospital engaged with staff and there was an annual Leadership MOT carried out. Patients were given opportunities to provide feedback about their experiences of the services provided and staff regularly engaged with patients waiting for appointments.

Staff in all outpatient areas stated they were well supported by their managers. They were visible and provided clear leadership. Staff and managers told us there was an open culture. They felt empowered to express their opinions and felt they were listened to.

Vision and strategy for this service

The department managers demonstrated a vision for the future of services. They were aware of the challenges faced by the departments they managed and had action plans in place to address these challenges. For example, in physiotherapy, patient experience feedback was a challenge but managed corporately by Nuffield Health. Other challenges related to marketing and business growth

Staff were aware of the Nuffield vision and strategy and were seen to display the behaviours expected of them.

The organisational, local and departmental vision, strategy, goals and objectives were incorporated into the individual objectives of staff through the appraisal process.

Governance, risk management and quality measurement

Governance arrangements were in place, which staff were aware of and participated in. The trust had regular clinical governance meetings and team meetings. Heads of Departments (HODs) and Operational Team meetings were held to discuss incidents and items for the risk register. Monthly incident reporting data was reported to monthly governance meetings. Action plans were produced where trends were identified and monitored

Staff were given feedback about incidents and lessons learned, comments, compliments and complaints. Audits and quality improvement were also discussed.

The organisation had recently introduced a system to appraise guidance from the National Institute for Health and Care Excellence (NICE) to ensure any relevant guidance was implemented into practice.

The hospital had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were managing them appropriately. For example, physiotherapy, phlebotomy and radiology had identified risks associated with IT and equipment failure. Staff were able to clearly articulate contingency plans in place should equipment failure occur.

The pathology and radiology managers described how there were audit systems in place to measure the quality and accuracy of work carried out within the departments. For example, the radiology department benchmarked against national standards for image quality rejection rates. The service was performing better than the national average of 3% rejection rate scoring a rate of between 0.2% and 1.2% over the last 12 months.

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Staff completed regular audits on internal systems and routine practice against national guidelines. The most recent radiology audit results included anatomical markers; pre-processing: 78%, post-processing: 100%, Mammography: 95%. Validation of x ray reports was also monitored. Results showed that 100% of reports checked were correctly reported. Completion of imaging request referral forms was audited and the results showed 69% of forms were completed correctly. This score was mainly due to incomplete dates and signatures from medical staff. The scores had been reported at the operational team meeting and correct completion of forms had been seen to improve. The audit was due to be repeated in December 2014.

Within the medical laboratory service, laboratory test activity was monitored and any clinical governance issues picked up and highlighted by the consultant haematologist or microbiologist who were also available to medical staff for clinical advice.

Leadership of service

There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging services.

Staff in all areas stated they were well supported by their managers. They were visible and provided clear leadership.

Staff felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes.

Staff told us they would be confident to raise a concern with their managers if they needed to and felt listened to and engaged in the organisation.

Staff told us that leadership from the hospital director, matron and other managers was very open and honest. Managers were seen on a daily basis in departments throughout the hospital by all staff. Managers were known on first name terms, were approachable and encouraged questions and suggestions from all staff.

The radiology manager told us they felt supported in their role and they could escalate any concerns via simple and effective procedures and recognised pathways.

Culture within the service

Staff and managers told us the outpatient and diagnostic imaging departments had an open culture. They felt empowered to express their opinions and felt they were listened to.

Staff told us they were all encouraged to report concerns, record incidents and take part in team meetings. They all felt that these would be investigated fairly. They told us managers were open to comments and suggestions for improvements from staff.

Staff were encouraged to "take responsibility and to make decisions". They felt supported to do this every day.

Managers said they felt well supported by the organisation.

All staff we spoke with were proud to work for the Nuffield Health Hospital Tees.

Public and staff engagement

The hospital actively sought patient feedback. Staff regularly spoke with patients waiting for appointments to gather their feedback. Feedback was discussed at team meetings.

The hospital has a continuous cycle of patient surveys as well as taking part in the friends and family test. There was an action plan in place to address issues raised by patient feedback which demonstrated that patient experience was taken very seriously.

Physiotherapy patients were also asked to take part in patient feedback via an email or online survey. Staff reported this was a relatively new method of collecting feedback and had only yielded limited information.

Staff were given the opportunity to give feedback about their experiences of working at Nuffield Tees using the Leadership MOT. The latest results showed on the whole staff in the outpatients department were content. Of the eleven questions posed, three were rated as not meeting the expected standard. These related to staff having the right tools to do their job, opportunities to develop job skills and receipt of praise and recognition after good work. The hospital director was aware of these issues and managers were tasked with addressing them.

A consultant opinion survey 2013 showed medical staff either strongly agreed or agreed in response to questions about outpatient facilities, for areas such as flexibility to accommodate consulting times, appropriate level of nursing support, and whether outpatient facilities were good.

Innovation, improvement and sustainability

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Staff were encouraged to suggest ways to make departments run more effectively and efficiently.

In radiology, a radiographer had made patient access for a procedure safer and easier by using a different imaging tube and changing the size of the cartridge used. They explained the method was ergonomically safer for patients. The new method was discussed and recorded in the staff meeting minutes and has been adopted by the whole team.

Physiotherapists were trialling a new exercise group for back pain sufferers and had also introduced preoperative

group sessions for patients undergoing joint replacements to encourage better attendance in an aim to help patients attain realistic expectations of postoperative therapy and recovery.

Physiotherapists had developed a list of questions patients who had hip and knee replacements often asked and had approached consultants for their input in providing consistent answers and advice. This information was now available for physiotherapists to provide consistent verbal information to patients and used to develop improved written patient information.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

1. The provider should ensure all staff follow the hospital's infection prevention and control policies and procedures, particularly 'bare below the elbows' policy and the wearing of personal protective equipment.
2. The provider should ensure staff receive training and are aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and apply these in practice where appropriate.