The McIndoe Centre, part of Horder Healthcare

Quality Report

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

Ratings

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

Overall summary

The McIndoe Centre is operated by Horder Healthcare. The hospital has 19 beds. Facilities include three operating theatres, although one was decommissioned and under refurbishment at the time of inspection and outpatients. The hospital offers a wide range of surgical procedures, including, orthopaedics, general surgery and ophthalmology,

We inspected surgery and outpatient services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17th and 18th October 2016 along with an unannounced visit to the hospital on 21st October 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's

Summary of findings

needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

We rated this hospital as Good overall.

Horder Healthcare had a strategy in place. At the McIndoe Centre the strategy included the provision of a therapeutic location by carrying out a full refurbishment of the hospital, to provide an orthopaedic service along similar standards to that of the Horder Centre, the other location at which services are provided) and to invest in the staff to provide appropriate training and development to support practice.

The Interim clinical services manager and executive lead were visible on the floor and used a variety of strategies to communicate the vision such as staff forums, weekly communications bulletins, staff meetings, and individual objective setting as part of appraisal process

Staff knew the vision for the hospital and plans to develop it. The refurbishment programme in theatres was underway and staff were aware of the introduction of the orthopaedic service.

All the staff we spoke with on the ward,in theatre and in outpatients told us they were encouraged to report incidents using the electronic reporting system. Lessons learnt from incidents were regularly communicated through handovers, staff meetings, weekly communications bulletin, and information being placed in the ward communications board.

The Medical Advisory Committee (MAC) meetings took place quarterly and practicing privileges, quality assurance and new national guidelines were discussed along with key points from the Governance meetings.

The hospital has one employed Resident Medical Officer (RMO) and an agency RMO covering alternate weeks They are onsite 24-hours day seven days a week, on a rotational basis. The RMO undertook regular ward rounds to make sure the patients were safe.

The ward manager completed duty rotas two weeks in advance and any change on the day was clearly documented. Staff worked flexible hours to cover the rota and shifts included day, night, and twilight**.** Staff told us that extra patients can be added to the ward list up until the last moment which meant the ward was not always staffed safely.

At the quarterly Clinical Governance meeting the Director of Clinical Services, senior Clinical Managers, the Medical Director, the Chairman of the MAC, the lead Consultant Anaesthetist, the Resident Medical Officer and, where appropriate, other staff members and healthcare professionals review complaints and any trends identified. A summary of the Clinical Governance report was shared with the Medical Advisory Committee. Clinical complaints were reviewed at the Clinical Focus Group.

We saw a strong safety culture with policies and systems in place, and we saw that staff reported incidents appropriately.

There were robust governance systems that were known and understood by staff and which were used to monitor the provision and to drive service improvements.

We observed the staff on the unit being very kind, caring, and compassionate towards their patients. All patients and relatives we spoke with told us staff always introduced themselves, were polite, and treated them nicely.

We found areas of practice that required improvement in surgery.

In anaesthetic room one we saw the anaesthetic machine had incomplete checks on at least three occasions. This was not in line with the guidance for daily pre use checks from the Association of the Anaesthetists of Great Britain and Ireland (AAGBI) which provides assurance that anaesthetic machines work safely. The anaesthetic machine in theatre one also showed missed checks.

Professor Edward Baker

Summary of findings

Deputy Chief Inspector of Hospitals (London and the South East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Good**	We rated this service as good because it was, effective, caring, responsive and well-led, although it requires improvement for being safe. The McIndoe Centre incident reports for July 2015 to June 2016 consisted of 128 clinical incidents with 109 incidents occurring in surgery or inpatients. Fifty seven non clinical incidents were reported with only two incidents occurring in surgery. Incidents reported included cancellation of procedures, unplanned returns to theatre, extended length of stays and equipment not fit for purpose. All incidents were classed as low harm. We saw robust systems were in place to investigate incidents with the learning from each incident. Theatre one scrub up area had sensor taps and appropriate cleaning solutions in place. Hand washing sinks were compliant to national standards. The sterile services department had areas clearly designated with clean and sterile areas. All instruments were audited through the process with an internal system that tracked and enabled traceability of all instruments. There was also external monitoring of the system completed by the staff. However There was no evidence morbidity and mortality meetings take place. These meetings are peer reviews of complex patients or where there may have been concerns over the clinical care and lead to improved services. Hand washing audits were carried out by the infection control and prevention (IPC) nurse on a regular basis in both the ward and theatre areas. However, at the time of the visit the IPC nurse post was vacant. No recent hand washing audits had been undertaken. Data we reviewed for July 2016 showed compliance with hand washing was 75% on the ward. Further work was needed to improve compliance and prevent cross contamination.

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Outpatients and diagnostic imaging

Good

We rated this service as good for all key questions.
The hospital had an incident report writing policy and staff used an electronic incident reporting system. Awareness of how to report and respond to incidents was included in staff induction. Staff had a good understanding of how to use the system. Staff told us feedback from incidents was discussed at departmental meetings. We saw minutes of meetings which confirmed this. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn. Staff were able to give us examples of incidents that had been reported in the past.
We saw reported incidents were graded according to severity and investigated by the management team to establish the cause. These were then reported locally to departmental teams, the management board, the medical advisory committee (MAC) and other relevant organisations as required. The hospital had a robust audit programme throughout all clinical departments. Regular audits included patient health records, medicine management, hand hygiene and infection, prevention and control. We saw copies of these audits. Findings were reported to the departments and through to the management board meetings. Trends were identified and action plans created to improve the service to patients which was communicated back to the clinical departments for their action.
We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example, National Institute for Health and Care Excellence (NICE) guidelines.
Patients told us they loved the hospital and received great care. They felt listened to and received good explanations about their care. We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff always treated them with dignity and respect.
The provider told us Horder healthcare depended entirely on patient choice for its income and therefore focused the hospital to be responsive to patients needs and ensure this was forefront of planning and delivering care.
The outpatient department was open from 8am Monday to Friday and could stay open as late as 9pm if

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required. The department was open on Saturday mornings 8am to 1pm. Patients told us they had been offered a choice of times and dates for their appointments.
The outpatient department provided a health screening service which provided an appropriate range of tests and examinations based on clinical need. We looked in six sets of patient's records which indicated this was being completed. Reports went to patients and their GP if further investigations were required.
The overall responsibility for clinical governance and risk management lay with the director of clinical services who reported directly to the board of directors via a clinical governance subcommittee and the audit committee

Summary of findings

Contents

Good

The McIndoe Centre

Services we looked at
Surgery and Outpatient services

Summary of this inspection

Background to The McIndoe Centre, part of Horder Healthcare

The McIndoe Centre is operated by Horder Healthcare since July 2015. It is a private hospital in East Grinstead, West Sussex. The hospital primarily serves the communities of the East Grinstead area. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since April 2009.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

Our inspection team

Our inspection team was led by:

Inspection Manager Sheona Keeler Care Quality Commission

The hospital was visited by a team of CQC inspectors, and specialists in surgery and out patients.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• is it caring?

• is it responsive to people's needs?

• Is it well led?

Prior to inspection we risk assessed all services provided by the Centre using national and local data and intelligence we received from a number of sources.

Information about The McIndoe Centre, part of Horder Healthcare

The hospital has one ward and is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12 months before this inspection. This was the hospitals first inspection since registration with CQC, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (June 2015 to July 2016);

There were 1,680 inpatient and day case episodes of care recorded at the hospital in the reporting period (Jul 15 to Jun 16); of these 2% were NHS funded and 98% were other funded.

44% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 13,903 outpatient total attendances in the reporting period (Jul 15 to Jun 16); of these 100% were funded through non-NHS means.

116 consultants worked at the hospital under practising privileges and two regular resident medical officers (RMO). The McIndoe Centre employed 23.4 registered

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nurses, 8.8 healthcare assistants and operating department practitioners, as well as having its own bank staff. The accountable officer for controlled drugs had been in post over one year.

Track record on safety;

The hospital reported no never events in the reporting period from June 2015 to July 2016. There were no serious incidents in the same period.

There were a total of 128 clinical incidents in the reporting period (Jul 15 to Jun 16).

Out of 128 clinical incidents 85% (109 incidents) occurred in surgery or inpatients and 2% (two incidents) occurred in other services. The remaining 13% of all clinical incidents occurred in outpatient and diagnostic imaging services (17 incidents).

There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), in the period from June 2015 to July 2016

There were no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA) from June 2015 to July 2016

There were no incidences of hospital acquired Clostridium difficile (c.diff) from June 2015 to July 2016

There were no incidences of hospital acquired E-Coli from June 2015 to July 2016

The hospital reported seven complaints from June 2015 to July 2016.

Services provided at the hospital under service level agreement:

- Bariatric Services -Streamline Surgical
- Critical care level 2 and 3
- Dietetics
- Diagnostic imaging
- General waste disposal
- Hand Therapy
- Histopathology
- Histopathology including frozen section
- Maintenance Water
- Medical Equipment Service & Maintenance
- Medical Gas services
- Occupational Health Service
- Pathology including Blood Transfusion / Biochemistry/ Haematology and Microbiology
- Pharmacy Governance
- Physician cover
- Psychologist
- Radiation Protection
- Resident Medical Officer

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

All the staff we spoke with on the ward, in theatre and out patients told us they were encouraged to report incidents using the electronic reporting system. Lessons learnt from incidents were regularly communicated through handovers, staff meetings, weekly communications bulletin, and information being placed in the ward communications board.

The McIndoe Centre had not reported any never events or serious incidents in surgical services in the period July 2015 to June 2016 (Never Events are serious incidents that are wholly preventable)

Personal protective equipment (PPE) such as disposable aprons and gloves were easily accessible for staff. We observed staff wearing them when delivering personal care and we saw the housekeeping staff were wearing the appropriate PPE when undertaking full cleans in the bedrooms.

We observed alcohol hand gels were available in the patient rooms and outside each room. However PPE dispensers were at the beginning of each corridor. Staff told us if they had an infectious patient they would be nursed in the room nearest the PPE dispensers.

However

There was no evidence morbidity and mortality meetings take place. These meetings are peer reviews of complex patients or where there may have been concerns over the clinical care and lead to improved services.

The patient bedrooms and ward corridor had carpeted floors. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.

The hospital did not have an infection prevention and control (IPC) coordinator who was responsible for IPC within the hospital.

In anaesthetic room one we saw the anaesthetic machine had incomplete checks on at least three occasions. This was not in line with the guidance for daily pre use checks from the Association of the Anaesthetists of Great Britain and Ireland (AAGBI) which provides assurance that anaesthetic machines work safely. The anaesthetic machine in theatre one also showed missed checks.

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Are services effective?

Good

We rated effective as good because:

Staff had access to a range of hospital guidelines and policies via the intranet. We saw the majority of policies were up to date and referenced to current best practice from a combination of national and professional guidance such as the National Institute of Health and Care Excellence (NICE) and Royal College guidelines.

There had been 11 cases of unplanned readmission within 28 days of discharge between July 2015 and June 2016 and 18 cases of unplanned return to the operating theatre following a surgical procedure. We reviewed the data provided by the hospital and no trends were identified.

The medical records we reviewed during the inspection demonstrated that patients had their VTE risk assessed and addressed on admission with a 100% compliance screening rate. Data showed that no incidents of VTE's or Pulmonary Embolism (PE) had occurred between July 2015 and June 2016.

Are services caring?

Good

We rated caring as Good because:

We observed the staff at the hospital being very kind, caring, and compassionate towards their patients. All patients and relatives we spoke with told us staff always introduced themselves, were polite, and treated them nicely.

We left 'tell us about your care' comment cards on the ward. During the inspection nine comment cards had been completed. All comments were very positive and included 'I was treated with dignity and respect at all times,' 'what a lovely hospital, excellent treatment, attentive, friendly staff', amazing, everybody is helpful, friendly, and caring and care has been outstanding, the staff are amazing professional caring and friendly.

Are services responsive?

Good

We rated responsive as Good because:

All surgery carried out at the hospital was elective; staff reported the case mix was known in advance however, extra patients could be added at the last moment. Operating theatre lists for elective surgery were available in advance and patients could select times and dates to suit their family and work commitments.

A very small number of NHS patients (2%) were referred to the hospital by the Horder centre. The McIndoe centre would deliver the treatment and the patient would be referred back to The Horder Centre for follow up care.

Summary of this inspection

The outpatient department was open from 8am Monday to Friday and could stay open as late as 9pm if required. The department was open on Saturday mornings 8am to 1pm. Patients told us they had been offered a choice of times and dates for their appointments.

The outpatient department provided a health screening service which provided an appropriate range of tests and examinations based on clinical need. We looked in six sets of patient's records which indicated this was being completed. Reports went to patients and their GP if further investigations were required.

Are services well-led?

Good

We rated well-led as Good because:

Horder healthcare had a strategy in place. At the McIndoe Centre the strategy included the provision of a therapeutic location by carrying out a full refurbishment of the hospital, to provide an orthopaedic service along similar standards to that of the Horder Centre and to invest in the staff to provide appropriate training and development to support practice.

The Interim clinical services manager was visible on the floor and uses a variety of strategies to communicate the vision such as staff forums, weekly communications bulletins, staff meetings, and individual objective setting as part of appraisal process.

Staff knew the vision for the hospital and plans to develop it. The refurbishment programme in theatres was underway and staff were aware of the introduction of the orthopaedic service.

Surgical staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the on-going refurbishment plans will play a great role in enhancing patient's experience.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Surgery

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

Information about the service

The McIndoe Centre is an independent hospital in West Sussex that provides surgical services for private patients and a few NHS patients.

At the time of the inspection a refurbishment programme was underway which included the ward and theatre suite. Two theatres had been recently commissioned with the third theatre currently decommissioned. There was a four bed recovery area in theatres.

The hospital has 19 en suite bedrooms used for both inpatients and day cases providing a 24 hour, 7 day a week service. The ward has a reception area, sluice, clinical room, a medical record store, ward office, pre assessment room. The hospital does not have facilities to provide care and treatment for patients who are at risk from serious post-operative complications or who require high dependency interventions.

The service offers a range of surgical procedures including Ophthalmology, Maxillo-facial, Plastics (including minor hand surgery and cosmetic surgery), Breast Reconstruction, and Orthopaedics (limited at present).

Children service has stopped except for orthodontics, which was done as outpatient.

The normal hours of operating for this theatre are 0830 to 1730 - divided into a morning session (0830 to 1330) and afternoon session (1400 to 1730). This applies from Monday to Saturday. Sessions outside these times are on an adhoc basis and organised in advance with the Theatre Manager. There is an on call 'out of hours' theatre team available for any emergency return to theatre.'

In order to carry out the inspection, the Care Quality Commission (CQC) reviewed a large volume of performance data, spoke to patients and their relatives, held focus groups for staff, and listened to the views of the public as well as reviewing patient satisfaction questionnaire results. We spoke to three patients and fifteen staff during the inspection..

Good

Surgery

Summary of findings

Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights. The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service provided was regularly monitored. We found the clinical environments we visited and other communal areas in the hospital meticulously cleaned. Hospital-acquired infections were monitored and rates of infection were of a statistically acceptable range for the size of the hospital.

Outcomes for patients were good and the department followed national guidelines. Complaints were investigated and handled in line with standard policy. We saw the organisation use patient's complaints and comments used as a service improvement tool and the organisation actively encourage feedback from its patients and their relatives or loved ones.

Patients felt involved in planning their care and told us they received enough information about their conditions to be able make informed choices. They were given sufficient information by doctors and nurses so they understood their treatment and care options.

Patients had their individual care needs met and were actively involved in the planning of their care. Staff acted in patients' best interest and delivered an individualised service. They took into account patient's personal preferences and human rights. This meant that the service promoted person-centred care, promoted good health, wellbeing, and independence.

Access and flow through the hospital were found to be sufficient to meet patients' needs. Discharge procedures were in place and working in practice. There were sufficient methods of communication with external providers in place after a patient was discharged.

We found appropriate governance and risk management and quality assurance in place. This meant that identified risks and service quality was continuously monitored and improved upon. There was ample evidence that these systems and processes worked well and led service improvement and learning.

Good

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement

Incidents

- The McIndoe centre had not reported any never events or serious incidents in surgical services in the period July 2015 to June 2016 (Never Events are serious incidents that are wholly preventable)
- All the staff we spoke with on the ward and in theatre told us they were encouraged to report incidents using the electronic reporting system. Lessons learnt from incidents were regularly communicated through handovers, staff meetings, weekly communications bulletin, and information being placed in the ward communications board. We reviewed the theatre department meeting minutes for September 2016 and saw that incidents were discussed however, it was not evident that lessons learnt from incidents were fully discussed.
- Staff were able to describe the changes in practice following two reported incidents around the consent process. The learning from these included the introduction of a clutter free consent process and the introduction of a 'safer admission checklist'. In theatres there was a surgical time out when the patient arrives in theatre to ensure all documentation was complete and in place. No similar incidents have happened since the introduction of the new processes.
- The McIndoe centres incident reports for July 2015 to June 2016 consisted of 128 clinical incidents with 109 incidents occurring in surgery or inpatients. 57 non clinical incidents were reported with only two incidents occurring in surgery. Incidents reported included cancellation of procedures, unplanned returns to theatre, extended length of stays and equipment not fit for purpose. All incidents were classed as low harm. We saw robust systems were in place to investigate incidents with the learning from each incident.
- We reviewed the minutes from a variety of meetings including the Medical Advisory Committee (MAC), resuscitation meeting, clinical focus group and the quarterly Clinical Governance reports and saw incident reporting was a regular agenda item where incidents were discussed with learning outcomes. The RMO told us all relevant clinical incidents were reported and by attending the governance meeting was aware of all clinical incidents. The RMO had no concerns about raising issues.
- Staff we spoke with had a good understanding of the Duty of Candour requirement and were able to explain how it applied to their specific roles. In theatre we observed the Duty of candour flowchart.
- There was no evidence morbidity and mortality meetings take place. These meetings are peer reviews of complex patients or where there may have been concerns over the clinical care and lead to improved services. Patients that die are discussed to ensure the death was expected and not caused by poor clinical practices. No deaths have been reported in the period July 2015 to June 2016.

Safety Thermometer

- Safety thermometer data was being collected which included patient falls, wound oozing, cardiac arrhythmias, surgical site infections, and hospital acquired infections. All Key Performance Indicators (KPIs) were monitored and discussed at the clinical governance meetings. However, the data was not being displayed in public areas demonstrating a harm free care environment.
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We saw evidence of completed risk assessments in the patient records we reviewed.

Cleanliness, infection control and hygiene

- The McIndoe centre had a service level agreement (SLA) with a local microbiologist to provide services. This was reviewed annually. The microbiologist will link with the infection control nurse however there has been a gap of some months with no Infection prevention and control (IPC) nurse in post.
- The microbiologist worked with the nursing staff, consultants, and resident medical officer (RMO) to review relevant results and discuss these with the most appropriate person whether that was the RMO or consultant. Other duties included calls from staff to give advice, overview of water sample results, environment samples and look at samples following the refurbishment of theatre two.

Good

Surgery

- During the reporting period (July15 to June 16) no incidents of methicillin-resistant Staphylococcus aureus (MRSA) Clostridium difficile (C DIFF) and Escherichia coli (E.coli) were reported.
- In quarter two of 2016/17 infection control audits were undertaken which included the insertion of peripheral cannula and their ongoing care.
- Housekeeping staff had received appropriate training and were supplied with nationally recognised colour-coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination. Staff understood cleaning frequency and standards and said they felt part of the team.
- The patient bedrooms and ward corridor had carpeted floors. This did not meet the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment. The house keeping staff were able to describe how they would clean the ward corridor carpets six monthly and room carpets three monthly or following the discharge of an infectious patient. Disinfectant tablets were used in the carpet cleaner. We did not see any records of the deep cleans taking place. However, there were no concerns identified with infection rates.
- The housekeeping staff were able to demonstrate their daily cleaning log with the duties they perform. This included cleaning the shower rooms and placing clean towels in the bedrooms. A full clean was performed after a patient was discharged.
- Personal protective equipment (PPE) such as disposable aprons and gloves were easily accessible for staff. We observed staff wearing them when delivering personal care and we saw the housekeeping staff were wearing the appropriate PPE when undertaking full cleans in the bedrooms.
- We observed alcohol hand gels were available in the patient rooms and outside each room. However PPE dispensers were at the beginning of each corridor. Staff told us if they had an infectious patient they would be nursed in the room nearest the PPE dispensers. All bedrooms doors were able to display whether patients were being barrier nursed.
- The hospital used green ties to identify equipment was clean and ready to use. We saw ties on the ward on blood pressure devices, electrocardiogram units, and intravenous (IV) stands.
- In the theatre area male and female changing areas were in place. The female changing room was seen to be tidy and visibly clean with all staff belongings put away in lockers and made secure. Clean scrubs and a means of disposal were available.
- Theatre three was currently undergoing a complete refurbishment. The area between theatre three and the remainder of the department was seen to be completely sealed off with no sight of dust relating to the works underway. The theatre manager told us he has been involved in the planning of the building works and attends the project build meeting; however there was no involvement of a lead infection control nurse as there was no IPC nurse currently in post.
- Theatre one scrub up area had sensor taps and appropriate cleaning solutions in place. Hand washing sinks were compliant to national standards.
- The sterile services department had areas clearly designated with clean and sterile areas. All instruments were audited through the process with an internal system that tracked and enabled traceability of all instruments. There was also external monitoring of the system completed by the staff.
- The sharps bins in the areas we visited were not overfilled and were labelled and dated correctly.
- We observed most staff were bare below the elbow although we observed a consultant carrying out pre-operative assessments and not being bare below the elbows.
- Handwashing audits were carried out by the infection control and prevention (IPC) nurse on a regular basis in both the ward and theatre areas. However, at the time of the visit the IPC nurse post was vacant. No recent hand washing audits had been undertaken. Data we reviewed for July 2016 showed compliance with hand washing was 75% on the ward. Further work was needed to improve compliance and prevent cross contamination.
- In each bedroom we visited, foot controlled waste bins were found in the bedroom and shower rooms. However, not all bins in the shower rooms were yellowed bagged to support clinical waste.
- All patients were swabbed for MRSA during their preoperative assessment. Staff told us patients colonised with an infection such as MRSA would be taken for surgery at the end of the theatre list to allow a thorough deep clean of the theatre prior to the next patient accessing the operating room the next day.

- The hospital had policies and procedures in place to manage IPC. Staff had access to the policies on the hospital's intranet and in policy folders on the ward and theatre.
- Clinical waste was separated and stored in line with national guidance.

Equipment and the environment

- There were three theatres with two having a laminar flow system. Theatre one and two have been refurbished and theatre three was undergoing refurbishment at the time of the visit and was not in use. There was one recovery area and storage areas for implants and separate general sterile stores.
- We saw a 'dirty corridor' running along the back of the theatres for the transport of dirty and used equipment.
- In theatre one new trunking with safety electrical cut off system had been installed. A swab board was in place, which was completed for each case. This enables clear sight of swab and sharps counts, tourniquet times, and checks.
- In anaesthetic room one we saw the anaesthetic machine had incomplete checks on at least three occasions. This was not in line with the guidance for daily pre use checks from the Association of the Anaesthetists of Great Britain and Ireland (AAGBI) which provides assurance that anaesthetic machines work safely. The anaesthetic machine in theatre one also showed missed checks.
- Equipment in the anaesthetic room was seen to be visibly clean and all had a record of being serviced and electrically tested. The theatre manager explained all new equipment was looked after by suppliers initially and then were managed by a London NHS trust who supplied a maintenance service.
- On the ward we saw a maintenance book where all equipment faults were logged. We saw faults were documented and repairs were undertaken by in house and contracted outside engineers. During the visit the outside maintenance engineer had attended and checked the equipment, this meant equipment was only out of service for a short period of time.
- In theatres staff fire and emergency action protocol was in place and fixed to the wall. Weekly departmental fire route check sheet was in place and completed.
- Procedures were in place and equipment was available to prevent and treat hyperthermia in patients undergoing surgery.
- All the bathrooms and bedrooms had call bells. We saw these were regularly checked. The call bells, when pulled were visible on a board at the nurses station
- Eighteen bedrooms were carpeted. This did not comply with the Department of Health, Health Building Note (HBN) 00-09: Infection control in the built environment hospital building note (3.82) that states carpets should not be used as this area has a high probability of body fluid contamination.
- The store room on the ward containing medical supplies and equipment required a key code for entry in line with best practice.
- Sterile supplies department was currently on site but was due to be decommissioned. The sterile services were audited in July 2015 and were compliant with standards at that time. There was a plan to take the service off site to the Horder centre and therefore a full audit has not been completed this year. There is an internal audit plan, which was on display in the department and was up to date and complete. Planned preventative maintenance was also displayed and was current.
- Small drug fridges in the recovery area were in the process of being decommissioned and new fridges installed. We saw in the ward medicine cupboard a new fridge had recently been installed. The temperature of the fridge in the recovery area was seen to be checked daily and the staff members knew what to do if the temperature fell outside of the expected range.
- In theatre we saw the storage area for implants. This was tidy and organised.
- Resuscitation trolleys were available on the ward and the theatre recovery area. We saw the oxygen was in date and the defibrillator was checked. Trolley checks were inconsistent, in the recovery area, as one weekly check had been missed. On opening the recovery trolley, all equipment was seen to be correctly listed on the checklist. Resuscitation council guidelines were seen to be 2010 and not the most recent guidelines from 2015.The missed checks were raised with the theatre manager during the inspection.
- Difficult intubation equipment was seen but not clearly labelled or clearly assembled on one trolley. The AAGBI guidelines "checking anaesthetic equipment" (2012) states "equipment for the management of the anticipated and or unexpected difficult airway must be available and checked regularly." The theatre manager told us a trolley had been ordered to address this.

- The recovery area had space for two patients but was due to be refurbished and will accommodate four trollies and two other patients. The refurbishment of the department was expected to be complete in February 2017.
- There was a system to review any alerts sent out by the Medicines and Healthcare products Regulatory Agency (MHRA) and ensure that the heads of departments were informed of any national safety alert. We reviewed the theatre meeting minutes and saw that MHRA alerts were raised and staff are asked to read the alerts and put any safety checks in place.
- A recent MHRA alert was around the use of paraffin based creams. The pharmacy technician checked the ward and theatre for the product. No products were found however more flammable cupboards have been sighted in the hospital to support the use of these products in the future.

Medicines

- The McIndoe centre had a SLA with the neighbouring NHS hospital for pharmacy support. The pharmacist attended the ward daily and reviewed prescription charts. A pharmacy technician employed by the McIndoe centre worked with the pharmacist proactively identifying patients due for discharge and ensuring all take home medications were available. There were specified arrangements for staff to gain emergency access to the pharmacy out of hours.
- The pharmacist would raise any medicine issues with the RMO or the interim clinical services manager.
- We reviewed four medication administration charts and saw they were fully completed, including details of any missed doses and the reason for this. Allergies were also clearly documented on each chart.
- The medicine room on the ward was entered through a controlled key pad. We saw controlled drugs (CD's) were stored in accordance with guidance. A CD register was in place, we saw CD's were tracked and signed out by two members of staff at all times. The records seen showed us staff were checking the stock levels in line with the hospital policy.
- In the ward medicine room, IV fluids, cylinders of Entonox and patient controlled analgesia (PCA) machines were all safely stored.
- The ward manager told us that Entonox was available for the removal of drains. The ward manager told us at present no training was available to support staff to develop the skill of administrating Entonox.
- A blue sharps box was available in the medicine room for the disposal of medicines along with the register the staff complete when disposing off medications.
- Fridge temperatures were recorded daily, on the ward and theatre in line with best practice. The temperature of the fridge in the recovery area was seen to be checked daily and the staff members knew what to do if the temperature fell outside of the expected range.
- Antibiotic usage was being monitored in the department. The microbiologist told us that antibiotic stewardship was discussed and will involve the RMO. An antibiotic policy was in place. We were told all administration of antibiotics was prophylactic however there has been no formal audit carried out to ensure best practice in the use of antibiotics was being followed.
- According to the hospital policy ward medicines auditing takes place every three months. The last audit was undertaken by the pharmacist two weeks ago. The pharmacist checks any issues and concerns and raises them with the management team. The pharmacist had no concerns as the hospital was responsive to any issues raised.

Records

- The hospital used a paper based record system to record all aspects of patients care. Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results and treatment and care provided
- Patient records in the surgical ward were stored securely to maintain confidentiality. Current ward medical records were kept in a locked cabinet behind the nurse's station. After discharge the records were stored in the medical records room that had a keypad controlled entry.
- Patients were offered a pre-operative assessment before their surgery. This process involved answering questions about their health, medical history and home circumstances. It also provided information to patients about what to do before admission as well as providing an opportunity for a range of basic tests and an infection screen.

- On admission the nurse would complete the risk assessment booklet. Patients had a range of risk assessments carried out. This included use of the Malnutrition Universal Scoring Tool (MUST), venous thromboembolism risk assessment (VTE) fall risk assessment, bed rails, and pain and skin assessments. Other documentation completed included a pre-operative checklist and care plan. In the three records we reviewed we saw the risk assessment booklets were completed for each patient on admission.
- We reviewed the care records of three surgical inpatients. We found prescription charts were signed and dated, with allergies documented. All patients were seen on daily ward rounds within 12 hours of admission and patient observations were recorded and completed at correct intervals. Nursing notes were good. All were dated, signed, and timed after each entry.
- We saw the theatre register was checked and contains a clear record of patient details, procedure, consultant, and key theatre staff. On reviewing the register we saw some detail relating to two patients was not complete. All other records on random checking appeared to be complete.
- The theatre manager was able to describe the process to safely check prosthesis's. Staff were responsible for writing the size on the booking form and diary before ordering. The prosthesis were checked on arrival and checked prior to the procedure and as part of safe surgery checklist.
- All details regarding breast prosthesis were entered onto the breast registry. This is in line with national guidance.
- We saw evidence the World Health Organisational (WHO) surgical checklist was completed correctly in the three records we reviewed. The WHO Surgical Safety Audit was completed on a regular basis and actions were put in place to amend any non-compliance.
- In a set of patient records we reviewed we saw a housekeeping checklist. This contained cleanliness check lists, what was in the room and whether it was fit for purpose and whether all essential equipment was available. This follows good practice guidelines.

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the hospitals safeguarding policy. All staff had completed level one safeguarding training for both adults and children.
- Nursing staff told us they would rarely need to make a safeguarding referral but were aware of who the safeguarding lead was and had contact details for the local authority safeguarding team. A folder was on the ward with all the relevant contact numbers and safeguarding process.
- The ward manager was the safeguarding lead for the hospital and was the first point of contact for any concerns raised on a day to day basis. Concerns would be escalated to the interim Clinical Services Manager and the appropriate safe guarding organisation. The safeguarding lead had received level three training. Discussions had taken place with the local NHS trust safeguarding lead to establish collaborative working. In the reporting period, the safeguarding lead told us one safeguarding alert had been raised. We saw hospital policy was followed when raising the one safeguarding alert.

Mandatory training

- The hospital had a mandatory training policy which specified the type of training each staff group was expected to undertake on an annual basis.
- Staff completed their mandatory training through the online system and attended face-to-face training. The ward manager told us there were gaps in the IPC training due to no IPC nurse being in post at present.
- Mandatory training included equal opportunities, risk management, medical gases, fire, and safeguarding training. All staff we spoke to had completed their mandatory training.
- Nursing staff completed intermediate life support (ILS).Records confirmed ILS was 100% compliant .ILS training takes place at the local NHS trust. Staff told us they were allocated time during the working day to complete their training.
- The substantive RMO completes e learning mandatory training as per the Horder Healthcare policy. The agency RMO supplies a list of in house training and an induction programme was then followed on their arrival at the hospital. Both RMOs attend external advanced life support training.

Good

Surgery

Assessing and responding to patient risk

- All patients attended a nurse-led pre-operative assessment prior to their surgery. We observed a pre-operative clinic and found the assessment to be thorough. Any concerns identified during pre-assessment were highlighted to the surgeon and an anaesthetist and a pre-operative anaesthetic review was booked as required.
- Staff identified any special needs patients may have and communicated this to the ward staff to ensure they were prepared to meet those needs on the day of admission.
- The hospital did not have the facilities to manage patients who required level two and three critical care support. We were told if a patient's condition deteriorates they would be transferred as an emergency to the NHS hospital where there was a SLA in place to provide critical care. This meant the hospital carefully screened patients during the pre-admission consultation to exclude operating on patients assessed as a surgical risk.
- The McIndoe centre had a SLA in place with the local NHS trust to provide a resuscitation service. If a crash call was made the team for the local trust would arrive on site to support. The RMO was part of the resuscitation team for the local NHS trust.
- One RN told us what would happen if an emergency was to happen. There was an internal alarm bell system to summon help in the case of patient collapse and cardiac arrest. This included dialling 2222 for the resuscitation team from the neighbouring NHS trust. The RN confirmed attendance at intermediate life support training.
- The ward was using the National Early Warning Score (NEWS) scoring system to identify and escalate care of any deteriorating patients. When a patient was identified as deteriorating by nursing staff their concerns were immediately escalated to the RMO. The RMO was available on site 24 hours a day and reviewed any deteriorating patients immediately. If the RMO was concerned about a patient's condition they contacted the consultant to make them aware of the situation.
- A Service Level Agreement (SLA) was in place for the provision of a physician out of hours cover and support and was contacted to attend any deteriorating patients or for returns to theatre. A SLA was also in place to cover radiology needs out of hours.
- The theatre department had implemented the World Health Organisation (WHO) five steps to safer surgery. There was an established audit process that demonstrated 90% compliance for June 2016 and 100% compliance for September 2016.
- Data provided by the hospital showed the VTE assessment target of 100% was met in June and August 2016.
- Blood for transfusion was ordered in for named patients where it was needed for elective surgery. The department also kept a stock of O negative blood on site for emergencies.
- The duty sister had a folder giving access to emergency support. This included on call rotas, escalation process for the transfer of the patient and other clinical emergency processes.
- The designated consultant is contactable at all times when they had inpatients in the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk. Consultants made suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- The anaesthetists in charge of the list were responsible for patient airway management in the first 24 hours post- surgery and were available in case there were any requirements to return to surgery. It was usual for the anaesthetist to be available for the duration of the patients stay, however, if they were not available the neighbouring NHS trust will provide emergency support via the on call service.
- The theatre 'safety time outs'' took place prior to the start of every list and provided an opportunity for the team to ensure all staff understood their responsibilities, they checked that all the equipment was available and discussed the order of the list. We saw these 'safety time outs' were well led and gave all members of the team an opportunity to input into the discussions.
- Patients discharged are given the contact number of the ward and are told they can contact the ward at any time with any queries they may have. The nursing staff complete a template documenting the telephone conversation. Nursing staff could then arrange for the patient to be reviewed by the RMO or the consultant if any serious concerns were raised.
- The theatre manager told us any risks were discussed at the Heads of department meeting monthly and the

governance meeting. Any new procedures the consultants want to introduce into theatre must be agreed with the Medical Advisory committee. (MAC) The theatre manager has now started to attend the MAC.
- We saw appropriate evidence that pregnancy testing took place for all patients of childbearing years undergoing a procedure which needed sedation or general anaesthetic.

Nursing staffing

- The ward manager completed duty rotas two weeks in advance and any change on the day was clearly documented. Staff worked flexible hours to cover the rota and shifts included day, night, and twilight. Staff told us that extra patients can be added to the ward list up until the last moment which meant occasionally staffing numbers were below those planned for the number of patients but this did not compromise care.
- The ward had an establishment of 12.3 whole time equivalent (WTE) registered nurses and 4.0 wte HCA's. However, staff told us that some key senior staff members had left recently. Staff felt the ward was understaffed. One agency nurse was regularly employed to support the ward.
- We observed the nursing handover and found it to be a structured and effective communication tool which promoted continuity of good care. The handover took place in the ward office to protect patient confidentiality and privacy. Relevant information including NEWS which indicates any risk of deterioration was discussed.
- In theatre one member of staff was pregnant. We saw the relevant risk assessments were completed with follow up meetings in place.
- In theatre establishment was 2.8 WTE operating department practitioners (ODP) and Health care assistants (HCA) with 9.1 WTE registered nurses (RN).The ratio of nurse to OPD and HCA of 3.3 to one. The theatre manager told us five WTE staff were needed to bring the staffing levels up to establishment
- A new orthopaedic lead nurse was due to start at the McIndoe centre. We were told by the theatre manager there was a lead for plastics and a lead for anaesthetics who was also the resuscitation lead and had attended an advanced life support (ALS) course.
- We reviewed the data and saw that over the reporting period (July 2015-June 2016) the use of bank and agency for theatre nurses was lower than the average of other independent acute providers. However on the day of the inspection two agency nurses were on duty.
- The use of bank and agency for theatre ODPs and HCAs was lower than the average of other independent acute providers.
- Two members of staff worked in the sterile stores department. With the proposed transfer of the service the staff had been in consultation since November 2015.

Medical staffing

- The McIndoe centre has two RMO's . One RMO been employed by the organisation for the last 10 years, the second RMO was contracted to the hospital by an external agency. Each RMO worked a week on and had the following week off. The RMO has been allocated a responsible officer who undertakes the annual review.
- The RMO took clinical responsibility for the patients 24 hours a day. The RMO's were supported by individual consultants who were contactable twenty four hours a day by telephone. The RMO's told us consultants were approachable and provided appropriate support.
- The surgical ward had 24 hour consultant led care with each consultant taking responsibility for their own patients. Consultants remained on call whenever they had patients in the hospital.
- In July 2015 Horder Healthcare invited all medical staff to reapply for their practising privileges. Any of those who did not respond or who did not provide the appropriate evidence had their practising privileges removed. Medical staff affected were informed of this in writing.12 consultants had their practising privileges removed.

Major incident awareness and training

- The McIndoe centre had a business continuity plan in place with various scenarios that may affect the day-to-day running of the ward and theatres such as loss of mains water supply, loss of the telephone supply and interruption in the electrical supply. We saw procedures in and out of hours were in place along with the contact details of all relevant persons and emergency response numbers.
- In theatre we saw a folder containing major incident information. The folder contained up to date rotas, consultant contact numbers, and key policies.

Good

Surgery

- The interim clinical services manager told us the telephone lines went down recently which resulted in placing the business continuity plan into action. This included setting up of a control room from where all incidents were logged. All critical areas had mobile phones in place, the RMO was based on the ward, and the local NHS was put on alert. At the end of the incident a debriefing took place to discuss what went well and what didn't go well.
- The McIndoe work collaboratively with the local NHS trust. In the evident of a major incident consultants and nursing staff would be released, if required, to provide support.

Are surgery services effective?

Good

We rated effective as good:

Evidence-based care and treatment

- The ward manager told us senior nursing staff and the RMO visit all patients daily to ensure individual concerns are identified and appropriately actioned.
- Staff had access to a range of hospital guidelines and policies via the intranet. We saw the majority of guidelines were up to date and referenced to current best practice from a combination of national and professional guidance such as the National Institute of Health and Care Excellence (NICE) and Royal College guidelines**.**
- A review of the breast reconstructive pathway identified gaps in the care delivered. The Breast care nurses from the neighbouring trust support the consultant by undertaking joint reviews in clinic. However, gaps exist at pre assessment and on the ward. The interim clinical services manager told us that steps were underway to introduce specialist nurse support on the ward, pre assessment and follow up.
- A SLA (Service Level Agreement) with a UK accredited pathology laboratory was in place to supply blood. We saw protocols for the blood fridge and major haemorrhage. Both protocols were in date and were based on national and professional guidance.
- Staff nurses told us as part of the integration with Horder healthcare they were developing patient pathways which have never been in place before. We were told by a RN the breast reconstructive pathway was being developed. This would include a more holistic approach to care covering areas such as pre and post nutrition to enhance recovery. At present the post-surgical care was four/five days in hospital. The aim through advanced recovery interventions was to reduce the hospital stay to three/four days.

Pain relief

- Prior to admission the patient completed a medical questionnaire and during the pre-assessment process individual concerns regarding pain were reviewed and documented. Any concerns identified were raised with the RMO and consultant. We saw evidence that patients had their pain needs assessed at their pre-operative assessments.
- On admission the NEW score was used on all patients ensuring there was a review of pain scores. Escalation protocols were in place. Any escalation from NEWS was reviewed by the RMO. A pain chart was available which used a stepped process to monitor pain following surgery.
- The service provided a range of analgesia options to patients including oral, intravenous and Patient Controlled Analgesia (PCA**).** One patient we spoke to told us pain relief was good and was offered regularly, another patient thanked staff for talking me through the pain in the middle of the night' .Guidance on the use of PCA was available for staff to review.
- We saw a pain management policy was in place however, it was due to be reviewed 6 months ago.
- A pain audit was undertaken regularly. 20 patient records were reviewed to ensure adequate pain management was in place post operatively.

Nutrition and hydration

- Nursing staff assessed nutrition on admission using the Malnutrition Universal Screening Tool (MUST) and we saw the MUST was completed in all the records we reviewed.
- Any patients identified as being at risk of getting de-hydrated will have all fluid intake and output recorded on a fluid balance chart. A 24 hour fluid balance will be reviewed and appropriate action taken to address any concerns. We saw fluid balance charts in the medical notes we reviewed however no patients were having their fluids monitored during the visit.

- The hospital did not have a dietician or a speech and language therapist (SALT) but staff told us they were able to access support from the neighbouring trust when required**.** The SLA with the neighbouring trust ensures a review was performed within 24 hours of the request being made.
- Any dietary requests would be discussed at the pre assessment clinic and the catering manager would be informed to ensure dietary requests were in place for the patient on admission. Any dietary requirements were placed on the notice board in the ward kitchen so all staff were aware.
- One patient we spoke to told us the 'food was very good" and "Nothing was too much trouble for staff to prepare."

Patient outcomes

- Between July 2015 and June 2016, there were two unplanned transfers of inpatients to a local acute trust because their condition had deteriorated. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified**.** However, staff were able to describe the reason for one of the transfer's but were unable to recall the reason for the second transfer.
- When a patient was transferred the RMO would regularly phone the trusts for updates of the patient's condition. On discharge, the patients received follow up care at the McIndoe centre.
- There had been 11 cases of unplanned readmission within 28 days of discharge between July 2015 and June 2016 and 18 cases of unplanned return to the operating theatre following a surgical procedure. We reviewed the data provided by the hospital and no trends were identified.
- The medical records we reviewed during the inspection demonstrated that patients had their VTE risk assessed and addressed on admission with a 100% compliance screening rate. Data showed that no incidents of VTE's or Pulmonary Embolism (PE) had occurred between July 2015 and June 2016.
- Hospital staff told us the organisation was working with the 'Private Healthcare Information Network' to improve reporting of patient outcomes across the independent healthcare sector. They hoped this would make patient outcome data more easily comparable with NHS providers.
- Data was provided regarding surgical site infection rates. In the reporting period (July 2015-June 2016) five surgical site infections were reported. One incident was of a reported PVC related cellulitis and a methicillin-resistant Staphylococcus aureus (MRSA) positive result. A full investigation was completed. The report was presented at the IPC meeting. A letter was sent out to staff regarding correct management of PVC lines.
- Cannulas were dated on insertion and documentation demonstrated regular checks for signs of phlebitis
- The McIndoe centre had a comprehensive audit programme in place. This included audits around medicine management including CD drugs, fridge temperatures, sharps boxes, and resuscitation equipment. We reviewed the audits and saw that action plans were put in place if the audit was not 100% compliant.

Competent staff

- We saw data that confirmed 100% of staff appraisals had been completed for theatre operating department practitioner's and health care assistants in the current appraisals year (Jan 16 to Dec 16). Staff appraisal rates for theatre registered nurses in the reporting year were 75%.
- On the inpatients ward staff appraisal rates were poor. Data confirmed that only 33% of registered nurses had received an appraisal which was the same as the previous year and below the provider's target. We spoke to two registered nurses who confirmed they had received appraisals this year.
- The interim clinical services manager told us they are encouraging staff to focus on their skills and development. Two staff were completing a mentorship programme and another a counselling course. We were told that the hospital was in the process of restructuring nursing with development of a practice development nurse and internal rotation of staff to night duty to improve professional development.
- Competencies around medicine management for nurses had been introduced into the induction process.
- The inpatient HCA'S appraisal rate had fallen this year to 20% from 60% last year. A HCA told us they had been supported to complete relevant competencies and has just completed care certificate. This had been supported by Horder healthcare.

- The RMO was up to date with mandatory training for advanced life support (ALS).To keep the RMO's skills up to date the RMO was part of the neighbouring NHS 's trusts resuscitation team and would attend training and crash calls.
- Ward staff did not have regular one-to-one meetings scheduled with their line managers. Staff told us there had been so many changes in a short period of time and there was little time for one to one meetings.
- The hospital had a competency based training programme for nurses and HCAs. We saw each staff member had a personal competency and mandatory training folder where they stored their certificates and recorded evidence of learning and development. This was also used as evidence towards revalidation. We reviewed an HCA's folder and saw role specific competencies had been undertaken for phlebotomy and taking of electrocardiograms (ECGs.)
- Staff told us they were encouraged and given opportunities to develop their skills. One registered nurse told us a pain study day had taken place which covered areas such as the pain ladder and the importance of pain management. With the hospital introducing orthopaedic work a two day study day had been arranged by the orthopaedic clinical nurse specialists. Staff we spoke to were due to attend the orthopaedic study days.
- Staff spoke positively about the resident medical officers (RMOs) and their support in delivering care and treatment to patients. The RMO's had a named consultant as the responsible officer who will conduct the annual review. The consultants provide professional and peer support.
- In theatre, one qualified nurse had been trained to be a first assistant. Any other staff coming to the hospital to assist consultants must submit relevant information in line with policy before they could work within the theatre.
- All new staff including agency staff were inducted into their area of work. We saw a corporate checklist was in place including an induction booklet, departmental induction process; buddy allocated and fire safety procedures. We were shown completed induction checklists which outlined department orientation and familiarisation with specific policies.
- In theatre, we reviewed an agency nurse's induction programme. We saw induction had followed hospital policy along with occupational clearance, registration details, and mandatory training record.
- The theatre manager told us all new consultants undergo an informal induction around the theatre suite and if the theatre manager has any concerns about their practice, this was be escalated.
- The pharmacy technician was a lone worker. The senior management team had, through the SLA, taken steps to get professional support. The pharmacy technician received support from the pharmacist and attended the medicines alert forum at the neighbouring NHS trust.
- The consultant medical secretaries were employed by the consultants. The medical secretaries had to complete hospital mandatory training and follow hospital policies.

Multidisciplinary working (related to this core service)

- It was evident that there was a functional multidisciplinary approach to the care delivered in the surgical department. The documents we reviewed and the staff we spoke with confirmed this.
- The hospital had appropriate Service Level Agreements (SLA) with local providers. SLAs covered areas including critical care, resuscitation support and training, histopathology and pharmacy.
- We reviewed three sets of medical records, in one set of records, there was a lack of information regarding multidisciplinary team meeting in the medical records of a patient receiving surgery for the management of cancer.
- There were no formal multidisciplinary meetings held for surgical patients.
- During the inspection, we observed good team working between nurses, theatre staff, pharmacist, and RMO.
- We found throughout the hospital, staff worked collaboratively to promote the health and well-being of the patients. It was a small hospital and all staff groups knew each other and were fully involved with improving patients' health and recovery both before and after surgery.
- We observed positive interactions and collaborative working between the ward and theatre staff and in theatres between the surgeons and theatre staff.

Seven-day services

- Consultants provided on-call cover for the duration of their patient's hospital stay.
- The hospital had an on call rota for pharmacy and radiology if support was required out of hours, as well as an on call emergency operating department team.
- Patients were advised to contact the ward staff if they had any concerns out of hours.
- Senior managers had an on call rota and were available to staff 24/7.

Access to information

- There were systems in place to ensure that staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner. This included test results, risk assessments and medical and nursing records.
- There were paper-based records for each patient; one for medical notes and one for nursing notes; nursing records including observation charts were accessible in the patient's room. This enabled consistency and continuity of record keeping whilst the patient was on the ward, supporting staff to deliver effective care.
- Staff showed us how to access key policies and standard operating procedures on the hospital's intranet.
- We found the department provided information which supported patients and their relatives to make decisions about their care and treatment. At the pre assessment clinic, all the necessary patient information leaflets were given to the patient prior to the procedure. All patient information booklets were available electronically produced by an external provider.
- Following patients' discharge their medical notes stayed on the ward until post discharge checks were completed. Once completed, records were taken to an on-site medical records storage room. If clinical staff needed to access medical records administrative staff could retrieve them in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The McIndoe centre had a consent policy in place which was due to be reviewed in 2019.
- In the three patient records we reviewed all patients had been consented for their surgical procedure. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient. Consents were completed on the ward prior to surgery. Staff we spoke with, both in theatres and on the wards were aware of the consent policy and the correct procedures to ensure patients gave valid consent prior to any treatment or surgical intervention. However, two incidents had occurred where the consent was not signed prior to surgery. An investigation had taken place and systems had been put in place to prevent this happening again.
- One patient we spoke to told us they had received lots of written and verbal information and time to make a decision regarding the surgical procedure. A second consultation was arranged to confirm, they were happy to proceed. Consent was then undertaken after the period of reflection on the morning of the procedure.
- All staff received training in the requirements of the Mental Capacity Act 2005 (MCA) as part of their mandatory training. We saw the Mental Capacity policy and documentation to undertake mental capacity assessments were in place.
- Staff we spoke with had received training and were aware of Deprivation of Liberty Safeguards (DoLS) principles. However, staff explained they did not have experience of completing a DoLS application. A DoLS policy was in place.We saw DoLS training took place in December 2015 and July 2016. Five members of staff attended the training.

Are surgery services caring?

Good

We rated caring as good

Compassionate care

- We observed the staff on the unit being very kind, caring, and compassionate towards their patients. All patients and relatives we spoke with told us staff always introduced themselves, were polite, and treated them nicely.
- We left 'tell us about your care' comment cards on the ward. During the inspection nine comment cards had been completed. All comment were very positive and included 'I was treated with dignity and respect at all times,' 'what a lovely hospital, excellent treatment, attentive, friendly staff', amazing, everybody is helpful, friendly, and caring and care has been outstanding, the staff are amazing professional caring and friendly.

Good

Surgery

- One patient we spoke to told us she was well prepared for procedure and staff were caring and helpful and would they recommend the hospital. Another patient told us the staff had been "absolutely fantastic helpful, sympathetic and would explain everything" and were really approachable.
- The hospital reported consistently high (above 85%) Friends and Family Test (FFT) scores for the reporting period July 2015 to June 2016. The FFT is a simple test that asked patients whether they would recommend the hospital to their friends and family.
- Patient's privacy was maintained by ensuring the doors were closed during personal care or whenever patients needed some privacy with their relatives. We observed that staff always knocked before entering the room.
- Patients felt pleased and respected as they were involved, supported, and encouraged to be partners in their care and decision making right from the consultation meeting with the consultant, pre-assessment and discharge planning with any support they need.
- Every patient we spoke with was extremely complimentary about the care they received. Patients described the continuity of care as good, as they saw the same team of medical, nursing staff at each appointment. Patients informed us that they saw their consultant daily and the nursing staff are always in and out of their room to check how they were feeling.
- We observed one patient in the recovery area. The nurse looking after the patient was seen to be kind and caring and accompanied the patient back to the ward with the nurse who collected the patient from the ward.

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful to patients and their loved ones. They explained treatments in a way patients and relative could understand and kept them informed about their care.
- The patients we spoke with knew that names of the staff and who to ask for if needed. They all told us they felt able to ask questions and ask for help if required.
- Patients told us they had received information from the hospital on the type of surgery they were admitted for and they fully understood the care, treatment, and choices available to them. One patient told us 'the procedure was thoroughly explained to me and I was asked if I had any questions". I felt totally involved in my care'.
- All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharged home.
- Patients are informed of the cost of the procedures.

Emotional support

- Emotional support was mainly provided by the nursing staff on the ward. Support included reassurance from nursing and medical staff, and referrals to the appropriate professional. However, no specialist support was available for patients undergoing reconstructive surgery. The hospital was aware of the gap and was making arrangements to provide support through the training up of staff and arrangements from an outside provider.
- The hospital did not provide counselling services. However, the staff had access to a local chaplaincy service. One staff member told us they had never had to access the chaplaincy service.
- No support groups were available across the service.

Are surgery services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- All surgery carried out at the hospital was elective; staff reported the case mix was known in advance however, extra patients could be added at the last moment. Operating theatre lists for elective surgery were available in advance and patients could select times and dates to suit their family and work commitments.
- A very small number of NHS patients (2%) were referred to the hospital by the Horder centre. The McIndoe centre would deliver the treatment and the patient would be referred back to the Horder centre for follow up care.
- Private patients were generally referred to a consultant by the GP or via another consultant although a small number of patients were self-referrals.

Good

Surgery

- The hospital was implementing the Kings Fund – enhancing the environment. This had resulted in a number of changes including the use of more natural colour, more open spaces an improving signage..
- Bedrooms and shower rooms were accessible by wheelchairs to promote independence and the repositioning of soap dispensers had been implemented in the shower rooms.
- The hospital was in the process of introducing orthopaedic work .The theatre manager from Horder centre has been on site both to support the development of this additional specialty and to support the staff during the extensive refurbishment programme.
- The ward and theatre staff told us that they had good teams in place who could work flexibly if circumstances needed. Extra staff could be brought in if the workload was extra busy although this rarely happened. However nurses we spoke to told us that pain injections clinic were large with a recent clinic having 23 patients. All patients needed to be admitted and full risk assessments were undertaken. The RN told us this results in a huge workload at these clinics.
- All surgical patients discharged from the hospital, including those who had day case procedures, had the option of a telephone follow-up call to ensure they were managing at home. Any issues were addressed during the phone call, if possible, or patients would be booked in for an outpatient review with the consultant or nurse.

Access and flow

- The majority of the hospital's inpatient activity was surgical cases. There were 1,606 visits to theatre and 1,680 inpatient and day case episodes of care recorded at the hospital in the reporting period (July 15 to June 16); of these 2% were NHS funded and 98% were other funded. 44% of all other funded patients stayed overnight at the hospital during the same reporting period.
- Once a decision to operate was made in clinic, the bookings team worked closely with the consultant, ward staff, and the patient to agree a suitable date for surgery.
- Patients were offered a choice and staff strived to meet individual surgeon's and patients' requirements.
- The Theatre manager described the patient booking system which was undertaken by the admissions office. All bookings were agreed with theatre to ensure the correct kit was available for each case. No paediatric work was undertaken in theatre since July 2016.
- Day case patients who required admission had immediate access to overnight facilities, should they require them.
- A discharge pathway for patients was in use on the ward. This meant that staff could ensure that patients had all the relevant information they needed before their discharge.
- In the clinical governance report surgical reportable cancellations were discussed. Reasons for recent re scheduling of surgical procedures included abnormal blood test and positive pregnancy test.

Meeting people's individual needs.

- The hospital had a range of patient information leaflets available on the hospital intranet. During the pre-assessment clinic patients were given the necessary information. We saw an information sheet guiding patients on the nutritional requirements needed prior to surgery. The information sheet included information on 'what should I eat' and the 'nutrient's required to help wound healing'.
- All patients had individual rooms with en-suite facilities. Staff completed care rounds throughout the patients stay. These meant patients were visited in their rooms to check for example, if they were comfortable and needed anything.
- During our inspection, we observed call bells were answered immediately and staff were attentive to patient needs.
- Patients were offered a choice of food and drinks from a menu. A breakfast, lunch, and dinner menu was available. Special dietary requirements were catered for. One patient commented the 'meals were superb.'
- Staff had access to language line to assist communication with non-English speaking patients
- Information on special cultural, religious, or dietary needs was gathered at the pre-assessment stage and this information was passed onto the ward, catering department and theatre teams. One patient we spoke with told us 'staff were very attentive to my needs and made me feel comfortable.'

Good

Surgery

- A comfort bag was given to the private patients on admission. This contained slippers and toiletries.
- Any calls made to the hospital from a discharged patient were recorded on the 'record of clinical advice phone call'. We reviewed four records and found advice and actions were undertaken promptly. All information was reviewed by the RMO and contact was made with the consultant if necessary. All patients were called back by the RMO or consultant.
- The Dementia lead for the hospital had just completed training to develop this role. No other dementia tools were in place.

Learning from complaints and concerns

- The hospital received 7 complaints between July 2015 and June 2016. No complaints have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period. Complaints were divided into subject areas which included aspects of clinical treatment, communication and privacy and dignity.
- The Interim clinical services manager endeavoured to handle concerns/complaints at a local level but if unable to satisfy the complainant's issue, the complaint was escalated immediately to the Governance Office and a report made will be put on the complaints module of the Risk Management System. Any learning from complaints will be cascaded to the appropriate department and shared at Heads of Department meetings.
- Learning and actions identified from complaints were discussed with staff members involved and also, at team weekly hub meetings. Any learning for a particular member of staff was handled by the team manager through a personal action plan or counselling. Changes that have been made as a result of complaints which include Consultants and giving additional information in letters to patient in respect of bras to be worn post-surgery and ward staff have knowledge of online ordering system in connection with garment ordering to pass on to patients.
- Staff told us that if a patient was unhappy with any aspect of their care, they would try to resolve the issue verbally by asking the relevant professional to speak to the patient. They also offered a member of the hospital management team to meet with the patient. Learning from complaints was shared with all staff.
- There were effective systems in place to deal with comments and complaints, including providing patients with information about how to raise concerns or make a complaint. Patients and their relatives were supported to make comments and raise concerns.

Are surgery services well-led?

Good

We rated well led as good

- Horder healthcare had a strategy in place. At the McIndoe Centre the strategy included the provision of a therapeutic location by carrying out a full refurbishment of the hospital, to provide an orthopaedic service along similar standards to that of the Horder Centre and to invest in the staff to provide appropriate training and development to support practice.
- The Interim clinical services manager was visible on the floor and uses a variety of strategies to communicate the vision such as staff forums, weekly communications bulletins, staff meetings, and individual objective setting as part of appraisal process.
- Staff knew the vision for the hospital and plans to develop it. The refurbishment programme in theatres was underway and staff were aware of the introduction of the orthopaedic service.
- Surgical staff understood the hospital's aim to continuously improve quality and enhance patient experience. Staff felt the ongoing refurbishment plans will play a great role in enhancing patient's experience.

Governance, risk management and quality measurement for this core service

- Senior staff from the surgical services were engaged with governance activities at the hospital and represented theatres and the wards at various meetings, including infection control, heads of departments and clinical governance meetings.
- The hospital had a schedule of audits performed throughout the year showing the frequency of audit. A wide variety of audits were undertaken including infection control, pharmacy, pathology and medical records audits. Results were reviewed at governance meetings and the Medical Advisory Committee (MAC) meetings. Following that, results were shared with clinical departments.

- Clinical governance meetings were held quarterly and the minutes we saw showed these meetings were structured and well attended. Discussions at the meetings were focused on quality and risks and we saw areas such as incidents, complaints, risk register and the audit calendar were discussed.
- The MAC meetings took place quarterly and practicing privileges, quality assurance and new national guidelines were discussed along with key points from the Governance meetings.
- At the quarterly Clinical Governance meeting the interim Clinical Services manager, senior Clinical Managers, the Medical Director, the Chairman of the MAC, the lead Consultant Anaesthetist, the Resident Medical Officer and, where appropriate, other staff members and healthcare professionals review complaints and any trends identified. A summary of the Clinical Governance report was shared with the Medical Advisory Committee. Clinical complaints were reviewed at the Clinical Focus Group
- Hospital policies were in the process of being reviewed by the document control manager who would identify policies needing updating and send these to the heads of departments. All policies were allocated a named owner with a review date. We saw a spreadsheet which identified the policies already reviewed and the policies still to be reviewed.
- At the time of the visit 29 new policies had just been launched.These were new policies and the refreshing of already established policies.The reviewing and development of policies were overseen by a member of the senior management team. The Clinical focus group review all policies. All ratified policies are placed on the intranet and in folders on the ward. This was relayed to the staff through the weekly operational bulletin.Staff are asked to sign the policy to indicate they have read the policy.
- We saw infection control and resuscitation meetings took place regularly. Agenda items included policy updates, audit schedule, accidents/incidents, training, and medicine updates. All incidents discussed had outcomes documented and actions taken.
- Feedback from hospital wide meetings was disseminated to staff at local team meetings, via email, weekly bulletin, or the theatre weekly communications summary. Information feedback included learning and development, building updates, any theatre issues and health and safety. Team meeting minutes were shared with staff unable to attend.
- The risk register for the surgical wards and theatres was held and maintained by theinterim clinical services manager within the hospital. All risks were discussed at the Clinical governance meetings.

Leadership / culture of service

- There was a weekly mandatory meeting for all heads of department to attend. We reviewed the minutes of a recent meeting and saw the Quality and Safety improvement plan was discussed. Other areas discussed included policy updates, patient feedback and complaints, the governance action plan and health and safety or infection control issues.
- Morale across the department appeared to be high and staff described they enjoyed working as part of the team. Staff were proud to work for the hospital and enjoyed their role within the surgical team. Ward staff told us they worked well together and had good relationship with the theatre team and consultants they worked with regularly.
- The medical director was a member of the clinical governance group. All new policies were disseminated to the consultants at the MAC meeting along with the clinical governance minutes. At the last meeting we saw the Consent policy had been discussed. Two senior staff members meet with the consultants on a one to one basis, through emails and through the chair of the MAC.
- The interim clinical services manager told us a consultant's forum had recently taken place with ten consultants attending. The consultants were given the opportunity to give feedback. Subjects covered included booking policy and length of procedures. In theatre a communications diary was being developed to keep consultants up to date on the workings of the hospital between theatre lists.
- The senior management team was visible and staff on the ward felt able to feedback any issues straightaway.
- The pharmacist met quarterly with the interim clinical services manager. We reviewed the minutes of the June and September 2016 meeting and saw that any changes in prescribing are discussed along with incidents, and complaints. This demonstrated good practice.
- Staff told us they received training and were empowered to acquire new skills.

Good

Surgery

- All staff comments about the hospital were positive and staff described it being like 'a family'. They acknowledge it has changed since Horder healthcare had taken over but felt the pace of change was good. They have been kept informed of change and described the change as 'exciting'. However, some RN's did not feel supported by their line manager through this period of change.
- The sickness rate for theatre nurses was lower than the average of other independent acute providers in the reporting period (Jul 15 to Jun 16), except for three months when the rates were higher than the average.
- Sickness rates for theatre ODPs and HCAs were lower than the average of other independent acute providers in the same reporting period, except for in Jan 16 when the rate was higher than the average.
- There was a high level of staff stability for nurses in theatre and on the ward. There was no staff turnover for theatre staff in the reporting period (July15 to June 16). The rate of inpatient nurse turnover and other staff turnover was below the average rate of other independent acute providers in the reporting period.

Public and staff engagement

- Patient survey questionnaires were undertaken by the hospital. We saw that in the last quarter of 2015/16 compliance was at 98% and in the first quarter of 2016/17 97% of patients rated overall care as good/very good with 100% saying they would recommend the hospital.
- The consultant medical secretaries were employed directly by the consultants. The interim clinical service manager told us the secretaries were invited to team meetings and medical secretaries' forums.
- A HCA away day had taken place for the development of this staff group. This included discussions around the rotation to other departments to multi skill this staff group.
- All patients were actively encouraged to provide feedback. We saw examples of positive feedback and how changes suggested by patients had resulted in a change to the service delivered.
- The hospital was involved in breast awareness week. All previously treated patients were invited back to a 'pamper evening' to give feedback. Any information or comments made would be used to improve the present service.

Innovation, improvement and sustainability

- A risk assessment booklet had been introduced which meant all risk assessments carried out were easy to assess and were kept together.
- The hospital was actively looking at ways to improve the environment.

Good

Outpatients and diagnostic imaging

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

Information about the service

Horder Healthcare is the provider for The McIndoe Centre, an independent provider of outpatient and some diagnostic imaging services. The diagnostic imaging service is managed by a separate company under a service level agreement (SLA) and therefore not included as part of this inspection.

The outpatient department had 13,903 total attendances in the period July 2015 to June 2016. Of these 3,201 were first attendance and 10,702 were follow up appointments. All appointments were funded through non-NHS means.

Referrals are accepted for the outpatient and diagnostic imaging departments for adults above the age of 18 only. The hospital suspended its services provided for children and young people in July 2015. However, the orthodontic service for children was not immediately suspended as patients already using the service were half way through their treatment plan. Children still on their treatment plan would continue until its completion. All children were due to finish their treatment by the end of 2016.

The outpatient department has six consulting rooms, three minor operation rooms and one treatment room.

The facilities are focussed on elective care with defined operational hours. The department is open 8am to 8pm Monday to Friday and Saturdays 8am to 1pm. These hours are extended when the service dictates.

The outpatient service provides several specialities including, mole and cyst removal, varicose veins treatment, chemical fillers, scar revision, dental treatments (implants and straightening) and treatments for eye conditions (wet macular degeneration and glaucoma).

We spoke with and observed the care provided by 16 members of staff including nurses, health care assistants, administrators and managers. We spoke with five patients. We looked at six sets of notes, the environment and equipment staff used.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital.

Good

Outpatients and diagnostic imaging

Summary of findings

We found the outpatient services at The McIndoe Centre to be good. This was because:

- The hospital had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines. Areas we visited were visibly clean, tidy and fit for purpose. The environment was light, airy and comfortable. A wide range of equipment was available for staff to deliver a range of services and examinations.
- Medicines were stored in locked cupboards and administration was in line with relevant legislation.
- Staff kept medical records accurately and securely in line with the Data Protection Act 1998.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- The outpatient service had sufficient numbers of appropriately trained and competent staff to provide their services. Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- Staff interacted with patients in a kind, caring and considerate manner and respected their dignity. Patients told us they felt relaxed when having their treatment.
- The hospital was responsive to the needs of the local populations. Appointments could be accessed in a timely manner and at a variety of times throughout the day.
- Managers were visible, approachable and effective. The hospital had a management board and medical advisory committee (MAC) both responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good

Incidents

- No never events were reported in the period April 2015 to March 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong protective barriers are available at a national level, and should be implemented by all healthcare providers.
- The hospital reported no serious incidents or deaths in the period April 2015 to March 2016.
- The rate of incidents reported was higher than the other independent acute hospitals the Care Quality Commission (CQC) holds data for. There were 17 clinical incidents reported in the outpatient department. The majority of incidents reported related to post surgical wounds. Other incidents related to faulty medical equipment, incorrect labelling of specimens and allergic reactions to post-surgical dressings used.
- There were two non-clinical incidents reported in the period April 2015 to March 2016. This was similar to the rate of other independent acute hospitals. The incidents were a member of staff obtained a minor injury while lifting equipment and another member of staff losing their personal belongings (glasses).
- The hospital had an incident report writing policy and staff used an electronic incident reporting system. Awareness of how to report and respond to incidents was included in staff induction. Staff had a good understanding of how to use the system. Staff told us feedback from incidents was discussed at departmental meetings. We saw minutes of meetings which confirmed this. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn. Staff were able to give us examples of incidents that had been reported in the past.
- We saw reported incidents were graded according to severity and investigated by the management team to

establish the cause. These were then reported locally to departmental teams, the management board, the medical advisory committee (MAC) and other relevant organisations as required.
- We were told openness within the organisation was encouraged and staff were actively involved in evaluating and implementing lessons learnt.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken.
- Staff had a good awareness of duty of candour but had not had to demonstrate it; they told us they were open and honest with patients.

Cleanliness, infection control and hygiene

- There were no incidences of E-Coli, MRSA and MSSA bloodstream infections or cases of C.difficile related diarrhoea reported in the period April 2015 to March 2016 at the hospital.
- The most recent patient led assessment of the care environment (PLACE) score, completed from February to June 2016, was 99% for cleanliness which was better than the national average of 98%.
- All the areas we visited in the outpatients department were visibly clean and tidy and we saw there were good infection control practices in place.
- We were told the responsibility for infection prevention and control (IPC) was a coordinator who worked in partnership with the senior clinical team. The coordinator provided leadership for IPC within the hospital. We saw they kept surveillance records, data, completed incident reports, provided training for all staff and provided an annual report. The IPC officer met with the medical advisory committee (MAC) at the three monthly meetings.
- At the time of inspection the position of the IPC coordinator was vacant and we were told this position had been recruited and the candidate was due to start by the end of the year. In the meantime the head of clinical services oversaw the IPC of the hospital. They recognised there was a gap in the service and it was the responsibility of all staff to maintain infection standards. Additionally the hospital had strong links with a microbiologist at the local acute NHS trust who provided support and advice.
- The IPC committee met to discuss infection matters within the hospital. We saw the minutes for January and May 2016, which indicated this was occurring.
- The hospital had a gap analysis and action plan for IPC. There were 10 items listed including appropriate infection control awareness training for staff, reviewing the audit schedule and updating corporate policies. The analysis had action required listed, by who and completion date.
- The hospital had an infection control audit programme 2016 for infection control and the environment. This was completed March 2016 with an action plan and was updated July 2016. Areas highlighted included policies and procedures (71%) because they were not all up to date and we saw this was completed in July 2016. The audit also highlighted the environment including carpets and chairs (91%), this formed part of the replacement and refurbishment plan. The cleaning schedule for the carpets was to be vacuumed daily, deep cleaned every six months and spot cleaned as required. Areas highlighted specific to the outpatients department were in room 4 (80%) due to damaged cupboards, walls, carpets and date of curtain. The curtain was replaced June 2016 and the remainder were part of the fixtures and fittings refurbishment. Both toilets in the outpatients department scored 96% as they did not have a hand hygiene poster present. This was completed in July 2016. During the inspection we saw hand hygiene posters were present in all relevant areas. Disposable curtains were used in clinic rooms, dates on them indicated they had been changed within six months.
- The hospital audited hand hygiene for all staff across the unit including outpatient staff and consultants in March 2016. The audit showed there were inconsistencies in best practice of staff. Not all staff decontaminated hands before or after procedures with soap and water or sanitising hand gel. The audit was repeated in April 2016 and all areas scored 100% for registered nurses and health care assistants (HCA's) in the department. Out of 22 observations of consultants in the department, seven incidences were witnessed where the consultants did not use soap and water and

only sanitising gel or neither. We asked the head of clinical services the action taken to ensure consultants were complaint with hand hygiene. They were unable to provide an answer.

- We saw staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. Information was displayed demonstrating the 'five moments for hand hygiene' near handwashing sinks. Sanitising hand gel was readily available throughout the hospital.
- We saw personal protective equipment was available for all staff and staff used it in an appropriate manner.
- We saw disinfectant wipes were available in each room. Equipment was cleaned between each patient use and a sticker placed on it. We saw equipment with green stickers on, this meant the equipment was clean and ready for use.
- Some equipment was cleaned using a triple wipe cleaning system. We saw records which indicated all steps had been completed.
- We saw there were cleaning schedules in individual consulting and treatment rooms which were fully completed and comprehensive.
- In the treatment room, three minor operations rooms and one consulting room we saw flooring which was seamless and smooth, slip resistant, easily cleaned and appropriately wear resistant. This was in line with Health building Note (HBN) 00-09: Infection control in the built environment, 3.109.
- However, there were carpets in five consulting rooms. We saw the records which showed the carpets were vacuumed daily, deep cleaned every three months and spot cleaned when required. Managers told us the carpets would be removed as part of the refurbishment plan.
- We saw the seating in the outpatients department was covered with a wipe able fabric. This was in line with HBN 00-09 section 3.133 for furnishings which states all seating should be covered in a material that is impermeable, easy to clean and compatible with detergents and disinfectants.
- Waste in the clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw water was tested and reported to the water committee as required by the water safety management regime HTM 04-01. The required full annual check and appropriate monthly tests were completed.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1)d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.
- The hospital audited the sharps handling and disposal in March 2016. Overall there was good compliance and the hospital scored 100%.

Environment and equipment

- The PLACE scores were 94%, which was better than the England average for condition, appearance and maintenance of the hospital.
- The consultation rooms were equipped with a treatment couch and trolley for carrying the clinical equipment required. It had equipment in to provide physical measurements (blood pressure, weight and height). This was in line with Health Building note (HBN) 12 (4.18) which recommend a space for physical measures be provided so this can be done in privacy.
- We saw equipment service records which indicated 100% of electrical equipment had been serviced in the last 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw portable electrical testing stickers on equipment, which indicated the equipment was safe to use.
- We saw certificates to indicate staff were competent to use equipment. Staff reported no problems with equipment and felt they had enough equipment to run the service.
- Waste was disposed of and stored appropriately. The clinical waste unit outside the hospital was secure and all clinical waste bins we checked were locked.

- The hospital had an outside medical gas cylinder storage which was compliant with HTM 02-01. This states medical gas cylinders should be kept in a purpose built cylinder store that allows the cylinders to be kept dry, clean and secure to prevent theft and misuse.
- We saw an individual room for patients to have blood tests in. This is line with HBN 12,4.42 which recommends areas providing blood tests should provide individual cubicles for patients.
- Emergency equipment was available and located behind the reception desk for ease of access for outpatient staff. All equipment needed was available, as indicated by an equipment list. All consumables were in date. One staff member was responsible for carrying out weekly checks of the emergency equipment. We saw checklists were complete.
- Fire extinguishers were serviced appropriately and in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from obstructions.

Medicines

- The hospital did not have a pharmacy on site. Outpatient pre-labelled stock was available for patients to take home or a private prescription was given.
- Staff stored prescription pads in locked cupboards and a registered nurse held the key. Each prescription had an individual serial number which was recorded when issued. We saw registers in place for prescription pads for the outpatients department; this indicated when a prescription had been issued, to whom and what for. This was in line with guidance from NHS Protect, security of prescription forms, 2013.
- We found medicines were kept securely in locked cupboards with key pad access. A registered nurse held the key. The controlled drugs (CD's are medicines liable for misuse that require special management) were stored in appropriate cupboards which were locked, had restricted access and were bolted to the wall. The key to the CD cupboard was kept separately in a key pad access box. We saw the CD register was completed appropriately in line with relevant legislation for the safe storage of medicines.
- We saw the June 2016 audit of the medicines fridge. The audit found the fridge was visibly clean and defrosted and there was daily monitoring and recording of minimum and maximum temperatures except when the department was closed. We saw the records which indicated this was done regularly and appropriately.
- The local acute NHS trust audited the medicines management annually and was last completed in July 2016. The findings of the audit highlighted actions to be completed to ensure compliance with legal requirements and Horder Healthcare medicines management policies. The areas highlighted were for the hospital to ensure standard operating procedures were in date and regarding the checking and recording of ambient room temperatures. These were to be done daily the department was open for rooms that contained medicines. Any actions from normal temperature limits recorded, actions taken and documented. The audit highlighted the hospital required a risk assessment and action plan for staff to use in the event the temperatures were outside the expected range. We saw the actions of the audit had been achieved and the hospital was compliant in all areas.

Records

- The hospital used a variety of information technology systems that held patient data. All staff, clinical and non-clinical were required to be compliant with information security and data protection with all services around patients. We saw staff completed mandatory e-learning modules for information governance. Any adverse event was reported on the incident reporting system and the information governance officer informed.
- The provider told us if in the event a patient's records were required to be taken off site, a 'delivery records form' was completed with all relevant details prior to delivery as per the medical records policy. Porters were trained how to handle confidential information when transporting between sites. All records were tracked and could be located.
- Consultants who had practising privileges at the hospital were required to register with the Information Commissioners Office as independent data controllers and were required to work to the standards set by the commission. This included how patient's records were stored and transported.
- The provider told us that in the three months before the inspection no patients were seen in outpatients without all relevant medical records being available.

Good

Outpatients and diagnostic imaging

- We looked at six sets of patients records. We saw the records were complete, legible and signed. They contained referral letters, completed consent forms, results of diagnostic tests, surgical care notes, and discharge and clinic letters.
- All paper records, including consultations, were scanned onto the computer system. A second member of the administration team would check all documents from the paper record had been fully scanned. This meant an up to date medical record was accessible to all authorised staff via the computer system.
- Paper records were stored in the medical records department which could be accessed by authorised personnel only.
- Patient consultations were consultant led and individual consultants had access to their own patient records. In the event of a patient returning to the outpatient department, in an emergency, the registered medical officer (RMO) or another consultant could access any medical record of an inpatient episode either in hard copy or electronically.
- Medical secretaries ensured the clinic letters were available following an outpatient appointment and these were electronically saved on the patient administration system (PAS).
- We saw confidential waste was managed in accordance with national regulations. Confidential waste areas were available in administration areas and we saw the certificates of destruction supplied by the outsourced shredded waste company.
- We saw mandatory training records which showed us 100% staff in the outpatients department had completed information governance training.

Safeguarding

- There had been one safeguarding concern reported to CQC from April 2015 to March 2016.
- The hospital's ward manager was the lead for safeguarding with level 3 training for safeguarding adults and children and was supported by the clinical governance manager. The interim clinical services manager was responsible for escalating concerns through both the internal safeguarding structures and the local safeguarding board.
- The responsibility of a safeguarding lead is to ensure providers have the right systems and processes in place to make sure children and adults are protected from risk or actual abuse and neglect. National statutory guidelines: Working together to safeguard children- a guide to interagency working to safeguard and promote the welfare of children, 2015 states safeguarding leads are to be trained to level 3 for vulnerable children as the lead takes responsibility for the organisations safeguarding arrangements.
- Training records showed 100% of the staff in the outpatients department had completed the appropriate level of training for safeguarding adults and children.
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. They knew who the safeguarding lead was. We saw there was safeguarding flow charts displayed in clinical areas with clear instructions for staff if they had concerns or were worried about a child, young person or adult's welfare.

Mandatory training

- The RMO employed by the hospital completed mandatory training as per Horder Healthcare policy. The agency which supplied the RMO supplied induction at the hospital. We saw the hospital received assurances regarding the training and qualifications of the RMO from the agency.
- Staff were required to undertake an induction training course as soon as they started employment. The hospital had an induction policy and programme for all staff. This was designed to inform all new team members of Horder Healthcare's mission and values as well as organisational structure, strategy, policies and procedures.
- The content of the course was designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk. The training consisted of on-line learning supported with practical sessions.
- Staff held individual training folders. We saw the training records for five members of staff which indicated they were 100% compliant with mandatory training.

Assessing and responding to patient risk

- Medical cover was provided by the RMO 24 hours a day seven days a week. The RMO was selected on their experience to enable them to manage and respond to risks relating to the wide mix of patients at the hospital.

The RMO could attend to any patients in the outpatients department if required. The hospital showed us the assurances the RMO had attended external advanced life and advanced paediatric life support training.

- We were told the organisational, environmental and departmental risks were reviewed through the health and safety forum which reported the clinical governance committee and board of directors. Individual patient risks were assessed during any care or treatment which informed care planning. All patients were risk assessed and any identified or potential risks were addressed.
- In the outpatient department we saw risk assessments had been completed for the control of substances hazardous to health (COSHH), medical devices and aseptic technique.
- The outpatient manager had recently introduced a modified version of the World Health Organisation (WHO) 'five steps to safer surgery' checklist for minor operating procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), and sign out (before any member of staff left the theatre). We were told the checklist had not yet been audited, but there was a plan to do so.
- The hospital had facilities for some treatments which used light amplification by stimulated emission of radiation (LASER) therapy. We saw the laser was used in designated rooms and the warning lights and signs on the doors which were illuminated when the laser was in use. The key for the laser was kept securely away from the machine. This was in line with LASER safety guidelines (BS EN 60825-1:2007, safety of laser products: Part 1, equipment classification and requirements).

Nursing staffing

- The hospital employed two whole time equivalent (WTE) registered nurses and three WTE HCA's in the outpatient department.
- A registered nurse was always available in the outpatients while the department was open. We saw the staffing rota's to evidence this.
- During the reporting period July 2015 to June 2016, the use of bank and agency staff was 34% for nurses and 1.5 % for HCA's in the outpatient department. The data for use of agency or bank nurses was above the average and the use of agency or bank HCA's was lower than the average of other independent acute providers that CQC hold this type of data for throughout the reporting period. However there were no agency nurses and no agency or bank HCA's working in the outpatients department April 2016 to June 2016. There were no vacancies for staff in the outpatients department as at 1 July 2016.
- The rate of staff turnover for outpatient HCA's was higher than the average of other independent acute providers during the reporting period. There was no staff turnover for nurses during the same period.

Medical staffing

- Consultants were supported by an on-site resident medical officer (RMO) who provided a 24 hour medical presence. The RMO was on duty 24 hours a day and was based on site a week at a time. The hospital employed one contracted RMO and they used one regular agency RMO.
- The hospital had 106 consultants working with agreed practice privileges. This related to consultants in post at 1 April 2016 with more than 12 months service.
- We saw the McIndoe Centre practising privileges policy. We saw all medical staff had been fully trained to perform a procedure which they regularly performed within their NHS practice. The chief executive approves all practising privileges after consultaion with the Medical Director and interim clinical services manager, and was responsible for the granting and revoking of practising privileges.
- The granting of practising privileges is a well-established process within independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. There should be evidence that the provider has complied with legal duty to ensure that the regulation19 in respect of staffing. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We saw that these agreements were in place for all medical staff with practising privileges.
- In the reporting period July 2015 to June 2016, 12 consultants had their practising privileges removed and one was suspended (Consultant ophthalmologist). The provider explained the reason for the removal of the practising privileges was since the new ownership of the

Good

Outpatients and diagnostic imaging

hospital in 2015. All medical staff were invited to reapply for their practising privileges. Those who did not respond or who did not provide appropriate evidence had their practising privileges removed.

Major incident awareness and training

- The hospital had a business continuity crisis management manual, 2016, which included algorithms for action to take place for both in and out of working hours. The manual contained the actions plans in the event of loss of mains water, electricity and gas and action in the event of severe weather conditions and flood damage.
- Fire training was part of mandatory training for all staff. Staff told us there was a weekly fire alarm test on a Friday. Staff described what action to take in the event of a fire.
- Staff we spoke with gave us examples of responding to patients in an emergency (for example, cardiac arrest) and they felt the support and response from the rest of the hospital was immediate.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective

Evidence-based care and treatment

- The hospital had a robust audit programme throughout all clinical departments. Regular audits included patient health records, medicine management, hand hygiene and infection, prevention and control. We saw copies of these audits. Findings were reported to the departments and through to the management board meetings. Trends were identified and action plans created to improve the service to patients which was communicated back to the clinical departments for their action.
- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example, National Institute for Health and Care Excellence (NICE) guidelines.
- In the outpatient department staff demonstrated how they could access NICE guidelines and relevant policies on the hospital's computer system.

Pain relief

- In the outpatient department doctors could prescribe pain relieving medicines if required.
- Staff we spoke with told us when patients had undergone procedures; staff checked their experiences of pain regularly and offered analgesia when required. Patient pain scores were completed as part of routine observations and we saw these were completed.

Patient outcomes

- The hospital had regular review meetings where results were discussed with reference to how they could develop practices to improve upon services delivered. The hospital audited patient outcomes by providing clinical governance reports to the management board, medical advisory committee (MAC) and other specialist groups.
- The hospital measured patient outcomes with patient satisfaction surveys.

Competent staff

- The hospital ensured there were sufficient numbers of staff who had the necessary qualifications, competence, skills and experience and provided treatment appropriate to their role.
- We saw staff competency documents for nurses and health care assistants (HCA) in the outpatient department, all of whom had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when the professional registrations of staff were due and to ensure they were renewed. We saw evidence of these.
- We saw documents for a variety of areas such as mandatory training and completed induction packs.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC). The management told us they encouraged staff to enhance their qualifications where this matched operational requirements.
- The hospital had an appraisal policy to ensure that all staff understood their objectives and how they fit with the departmental and hospital objectives and vision. All the staff we spoke with had received an annual

appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with their regulatory bodies.
- The hospital's appraisal year ran from January to December. At the time of inspection 100% of nursing staff and HCA's in the outpatient department had received an appraisal

Multidisciplinary working (related to this core service)

- Staff told us they worked well together and had good communication with other health care professionals and administrative staff. We saw staff engage in a professional and courteous manner.

Seven-day services

- Seven day services and out of hour's services for the outpatients department were not provided at the hospital.

Access to information

- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). This is medical imaging technology which provides economical storage and convenient access to diagnostic images from multiple machine types. Other areas of the hospital were able to access the PACS system.
- Staff could access a shared drive on the computer where policies and hospital wide information was stored. Staff demonstrated this to us.
- We saw staff in the outpatients department had informal meetings every morning to share information and discuss any problems from the previous day.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent to treatment policy dated 2013. The policy demonstrated the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. The policy also incorporated the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance which set out procedures that staff should follow if a person lacked capacity.
- We saw signed consent forms in medical records. This meant patient's had consented to treatment as per the hospital policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were to be taken in their best interests.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good

Compassionate care

- The PLACE scores for privacy, dignity and wellbeing were 85% which were better than the England average. We saw all treatment and consultation rooms had curtains to ensure patients dignity was respected if the door was opened.
- Patients told us they loved the hospital and received great care. They felt listened to and received good explanations about their care. We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff always treated them with dignity and respect.
- We saw staff introduce themselves to patients and explain their role.
- We saw signs in the patient waiting areas informing patients they could have a chaperone, if required. We saw certificates which indicated staff had chaperone training. Staff would record if a chaperone had been offered and document if a patient agreed or declined. In a separate register it was recorded who had been a chaperone, the patient concerned and the day it occurred. We saw the chaperone register which indicated this was occurring. This was in line with the hospital's chaperone policy.
- During the inspection we asked patients to complete feedback forms to describe their experience of the outpatients department at the hospital. We collected 26 completed cards which were all positive about the

Good

Outpatients and diagnostic imaging

hospital and service received. Comments included: "very kind staff", "excellent, all round", "I am being looked after extremely well" and "all very efficient and punctual".

Understanding and involvement of patients and those close to them

- We were told nursing staff in the outpatients department asked patients the outcome of their appointment and fed back information to the consultants or other staff involved. Patients were asked to complete a feedback questionnaire. Feedback was also received through compliments, cards, letters and patient satisfaction questionnaires. The results of these were circulated throughout the department.
- The patient satisfaction questionnaires were collected by the patient services manager who determined whether a formal complaint needed to be documented. These were also reported at the monthly head of department meetings.
- Staff discussed treatments with patients in a kind and considerate manner.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need. They told us they received verbal and written information and sometimes a video disc explaining the procedure.
- We saw a variety of health-education literature and leaflets in the reception area. Some of this information was general in nature while some was specific to certain conditions.
- Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and it was in a clear and simple style and language.

Emotional support

- Staff could access counselling services and other psychological support for a patient if it was needed.
- We saw staff interacting with patients in a supportive manner and provide sympathy and reassurance.
- Nurses would attend clinic appointments with patients to provide emotional support if required. Staff told us they were able to provide patients and their families extra time if necessary.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- The provider told us Horder healthcare depended entirely on patient choice for its income and therefore focused the hospital to be responsive to patients needs and ensure this was forefront of planning and delivering care.
- The outpatient department was open from 8am Monday to Friday and could stay open as late as 9pm if required. The department was open on Saturday mornings 8am to 1pm. Patients told us they had been offered a choice of times and dates for their appointments.
- The outpatient department provided a health screening service which provided an appropriate range of tests and examinations based on clinical need. We looked in six sets of patient's records which indicated this was being completed. Reports went to patients and their GP if further investigations were required.

Access and flow

- The consultant's individual medical secretaries booked patients appointments and sent the appropriate information to the patient. The secretaries gave this information to the booking team who input the patient information and details of the appointment on the hospitals computer system.
- We were told the outpatient department did not routinely monitor clinic delays or cancellations. We were told this rarely happened and would mainly be due to a consultant having to reschedule. Additionally staff told us if the same consultant cancelled clinics regularly this would be investigated by hospital management.
- However, we saw the action plan for the outpatient department aimed to audit the late starting and finishing of clinics and patient waiting times. We were told the collection of the data had started and was not ready for analysis at the time of inspection.
- The clinics we observed ran to schedule, we did not see any patients wait more than five minutes.

Good

Outpatients and diagnostic imaging

Meeting people's individual needs

- The outpatient department had six consulting rooms, three minor operation rooms and one treatment room. The shared a waiting area and the main reception. We saw adequate seating available at a variety of heights and space available for patients to wait in wheelchairs. Access was suitable for wheelchair users and the hospital provided wheelchairs for use in the department if required.
- The waiting areas for the outpatients and diagnostic imaging departments had seating areas with refreshments, a television and magazines available for waiting patients and their supporters.
- Staff could tell us how they would access translation services for people who needed them. The hospital had a service level agreement with an external company to provide interpreters. However we were told these were rarely needed.
- We did not see any leaflets in any other languages apart from English. However staff told us these were rarely needed and they could access leaflets in other languages if required, from a central database.
- We saw the signs advertising the hearing loop in reception.
- Patients who were bariatric (severely obese) identified by staff when the referral was triaged. The hospital had couches and chairs which were limited to a maximum weight. Couches in the consulting rooms were limited to a maximum weight of 180kg and chairs in the waiting areas limited to 158kg.
- Staff received training on respecting equality and diversity in their mandatory training. At the time of inspection 100% of staff had completed the course and saw the records of this.
- Patients who were living with a learning disability or dementia were identified by staff when the referral was triaged. Staff told us if applicable, the appropriate individualised care and support would be provided.
- The PLACE score for disability (82%) was better than the England average. However the dementia was worse than the England average at 71%. This focuses on key issues such as flooring, decoration (for example contrasting colours on walls), signage, seating and availability of handrails which can prove helpful to people living with dementia. The centre had introduced the butterfly scheme at the beginning of October. We saw the training records for the staff who had attended the training. These included staff in the outpatients department and were in the process of being the link for patients living with dementia in the department.

Learning from complaints and concerns

- CQC directly received one complaint in the reporting period July 2015 to June 2016.
- Horder Healthcare recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure.
- Full details of the process were included in the 'listening to you' a guide to making comments and complaints booklet. We saw the booklets were available throughout the hospital and available on the website.
- The hospital had received seven complaints in the reporting period July 2015 to June 2016. No complaints had been referred to the ombudsman or an independent adjudicator. The assessed rate of complaints (per 100 inpatient and day case attendances) was similar to the rate of other independent acute hospitals CQC hold data for.
- All staff were encouraged and empowered to identify and address any concerns or issues while the patient was still on site. If needed, complaints were escalated to the hospital's operations manager while the patient or their relative was still at the hospital to prevent issues developing into a formal complaint.
- The responsibility for all complaints rested with the chief executive of Horder Healthcare. However the accountability for the completion of the investigation and response lay with the director of clinical services. The manager of clinical governance oversaw the concerns and complaints at corporate level. The day to day administration of complaints was handled by the hospital's complaints lead. They ensured an acknowledgement would be sent immediately upon receipt of the complaint explaining the investigation process and timescales.
- The Horder Healthcare complaints policy and process map set out the relevant timeframes associated with the various parts of the complaint response process. An initial acknowledgement was required within two

working days and a full response within 20 working days. If a complaint was escalated to a further stage the complainant would be given the information of who to take the complaint to if they remained unhappy with the outcome. For private patients they would be signposted to an independent adjudicator and NHS patients treated at the hospital, to the NHS Ombudsman.

- During the complaint investigation the process was monitored to ensure timescales were adhered to and responses provided within 20 working days. If a response was not able to be provided within this timeframe a holding letter was sent so they were kept fully informed of the progress of their complaint. All complaints information was retained within a paper file, with copies retained electronically and also stored in the hospital information management system.
- We saw complaints were discussed at all levels from board to team meetings. The board were informed monthly via key performance indicators. Clinical complaints were reviewed at the clinical focus group. At monthly departmental meetings relevant complaints were discussed with staff.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well led as good

Vision and strategy for this this core service

- We were told the mission of Horder Healthcare was to be a leading provider of high quality healthcare services which improved patient's health. The strategic aims were to maintain a robust business that was capable of generating a reasonable surplus in order to invest in the achievement of their purpose.
- The strategy for the centre was to provide a therapeutic location by carrying out a full refurbishment of the hospital. Their vision was to focus on plastic surgery and improve the orthopaedic service.
- We saw and were told the hospital aimed to invest in staff to provide appropriate training and development to support practice. Additionally they aimed to engage with stake holders and work together to provide an increase in knowledge and an improved service to customers.

Governance, risk management and quality measurement for this core service

- The overall responsibility for clinical governance and risk management lay with the interim clinical services manager who reported directly to the board of directors via a clinical governance subcommittee and the audit committee. The clinical governance committee recognised that clinical governance was the responsibility or every member of staff, both clinical and non-clinical. All staff were encouraged to participate in the developing, delivering and monitoring of the quality of services provided. Any reported variances were recorded on the incident reporting system, investigated and included in the quarterly clinical governance report. The process of reporting and investigating was implemented by Horder Healthcare within a fair, open and just culture looking at what and where improvements could be made within the system as a whole.
- We saw the quarterly clinical governance meeting involved the interim clinical services manager, senior clinical managers, medical director, chairman of the medical advisory committee (MAC), lead consultant anaesthetist, resident medical officer (RMO) and where appropriate other members of staff and healthcare professionals. Complaints were discussed and any trends identified. A summary of the clinical governance report was shared with the MAC.
- Clinical quality and governance issues were reviewed at the three monthly MAC meetings. This involved a high level of engagement from the consultants. The MAC was responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.
- We saw the minutes of the heads of department's monthly meetings and the three monthly centre operation board meetings. Items discussed included reports from the outpatients manager and infection control updates and issues.
- The hospital had its own risk register and the outpatients department had its own risk assessment. We saw the risks were clearly identified and mitigating actions were related. Items listed included the carpets in consulting rooms and staffing levels.

Leadership / culture of service

Good

Outpatients and diagnostic imaging

- The manager of the outpatient department reported to the head of clinical services, who reported to the executive director.
- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the outpatient department. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- The manager of the outpatient department was relatively new in post and we saw they had identified areas for improvement, for example updating standard operating procedures specifically regarding the minor operations performed.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Any changes made were communicated clearly and in a timely manner.
- Staff told us the hospital was a good place to work and everyone was very friendly. Staff felt they had sufficient time to spend with patients and were proud of the work they did.
- Staff we spoke with were overwhelmingly positive about the improvements occurring at the hospital.
- The rate of sickness for outpatient nurses was 0% throughout the reporting period (July 2015 to June 2016) except in February 2016 when the rate (20%). This was higher than the average of other independent acute providers CQC holds data for. The rate of sickness for HCA's was varied when compared to the average of other independent acute providers. Data for unfulfilled shifts were 1.0% in April 2016, 1.5% in May 2016 and 2.5% in June 2016.

Public and staff engagement

- We saw the latest patient satisfaction survey scored 97%. The hospital collected patient feedback twice a year via an online and telephone surveys. We were told this encouraged patient involvement.
- The hospital monitored patient satisfaction in all areas of its service delivery. Patient feedback was obtained via completed comment cards in outpatient areas, which we saw. The feedback was analysed by the management team and discussed at board level where the impact on service delivery was discussed. We were told the information was fed back to staff through team meetings and individually where appropriate. Service development was built around the outcomes of this information and formed part of the revalidation process for staff.
- The hospital had arranged alternative opportunities to collect patient feedback. We saw the advertising leaflets and letters inviting patients and their relatives to an art exhibition, where they would seek feedback about their experiences at the hospital.
- Staff competency feedback was collected in the patient comment cards as well as letters and cards received from patients. We saw the outpatient department had compiled a folder of compliments and thank you cards sent to the department.
- Staff told us managers shared information via email and newsletters. We saw noticeboards displaying information about infection prevention and control, health and safety, safeguarding and lessons learned from incidents and complaints.
- Staff told us they were engaged in the changes occurring at the hospital and senior managers consulted them about the changes, asking their opinion.
- We saw the hospital was in the process of obtaining feedback from staff with a staff survey. We saw the posters advertising this and the staff we spoke with were aware of the survey and had completed it. The results of the survey were not available at the time of the inspection.

Innovation, improvement and sustainability

- The management structure of Horder Healthcare meant individual members were familiar with all aspects of the business. Decisions taken at board level could immediately be implemented as actions and were allocated to those present and systematically followed up.
- We saw and were told, the staff in the outpatient department had identified areas for improvement. They were engaged in developing and delivering the department's action plan.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The hospital should have morbidity and mortality meetings. These meetings are peer reviews of complex patients or where there may have been concerns over the clinical care and lead to improved services.

The hospital should ensure all flooring meets the requirements of Health Building Notice (HBN) 00-09: Infection control in the built environment.

The hospital should have an infection prevention and control (IPC) coordinator who is responsible for IPC within the hospital.

The hospital should ensure anaesthetic machines had assurance checks in line with the guidance from the Association of the Anaesthetists of Great Britain and Ireland (AAGBI) which provides assurance that anaesthetic machines work safely.