The Horder Centre

Quality Report

The Horder 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

We rated this hospital/service as outstanding overall.

- One of The Horder Centre (THC) values was caring, which was embedded throughout the organisation from recruitment of staff and as part of their performance management. This was part of 'The Horder Way', which all staff were requested to sign up to as part of their induction.
- Patients' said that staff went the extra mile and the care they received exceeded their expectations.
- THC was part of the Specialist Orthopaedic Alliance (SOA) leading on orthopaedic service redesign as part of the national Vanguard project for NHS England. THC had undergone a complete refurbishment and redevelopment programme over the last eight years to create a therapeutic environment to aid patient recovery ensuring the flow of services within the building matches the patient pathway.
- The senior management team, supported by the Heads of Departments, had a good knowledge of how services were provided and were quick to address any shortcomings that were identified. They accepted full responsibility and ownership of the quality of care and treatment within their hospital and encouraged their staff to have a similar sense of pride in the hospital.
- 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.
- Medical Advisory Committee (MAC) meetings were undertaken quarterly and as part of a consultant's practicing privileges, they were required to attend at least two meetings a year. MAC meeting minutes showed the meetings were used to discuss improvements to patient care and ensure care was evidence based. For example, we saw in the April 2016 post surgery physiotherapy was discussed to ensure the best outcomes were achieved for patients.
- The MAC reviewed practising privileges every year. This included a review of patient outcomes, appraisals, General Medical Council (GMC) registrations and medical indemnity insurance. The hospital had a process to ensure all consultants were experienced and fit to care for patients.
- The centre's resident medical officers (RMOs) provided medical cover 24 hours a day, seven days a week. This ensured nurses could always quickly escalate any issues. The RMOs worked one week on and one week off duty.
- The centre used the Shelford Dependency tool and a Nurse Hours per patient day (NHPPD) tool, which provided an allowance of 5.5 hours NHPPD for inpatients. The centre acknowledged that this tool did not make individual allowance for each patient's dependency or care needs. Therefore, it was supported by the skills of the nurse in charge who considered these factors simultaneously when assessing nursing requirements.
- The clinical governance committee met quarterly and discussed incidents, complaints, infection control issues and risk register review. There was also a standing agenda item to review National Institute for Health and Care Excellence (NICE) guidelines, to ensure the centre implemented and maintained best practice.
- There was an effective system for identifying and reporting risk through the 'Horder Health and Safety teams'. The safety teams were responsible for ensuring risks were identified and placed onto the electronic reporting system. The teams were also responsible for ensuring investigations took place and learning was shared. This included feedback from audits, incidents, serious incidents requiring investigation and never events. They were also responsible for communicating any recommendations from the National Reporting and Learning System (NRLS), Health & Safety Executive (HSE), Medicines and Healthcare products Regulatory Agency(MHRA) and other safety alert notices to all staff across the centre.

Summary of findings

- The Horder Centre (THC) had a risk register which included nine risks, the register was centre wide. We reviewed THC risk register and noted that all nine highlighted risks had been reviewed within the last 12 months. We saw that all risks had controls in place to mitigate the risks.
- There was a positive staff culture with many staff having worked at the hospital for a very long time. These core staff offered stability and continuity which was balanced by newer appointed staff who brought a fresh perspective and allowed for the introduction of new ways of working.

We found areas of outstanding practice in surgery:

- The hospital told us it was the first hospital to submit data through to the Private Health Information Network (PHIN). PHIN is an independent, not-for-profit organisation that publishes trustworthy, comprehensive data to help patients make informed decisions regarding their treatment options, and to help providers improve standards.
- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicines.
- THC had successfully been accredited with venous thromboembolism (VTE) exemplar status. Organisations are awarded VTE Exemplar Centre status if they are able to demonstrate that they are delivering best practice as defined by the NICE Quality Standard for VTE prevention (QS3) and are taking an active role in their own local area in relation to disseminating best practice .For example, hosting VTE study days, educational events, contributing to publications and undertaking research).

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

Action the provider SHOULD take to improve

- The provider should consider the prominence of the hand gels to ensure their use by patients and staff.
- The provider should review it's policy on the use of Advance Decisions (AD) and ensure that staff are accurately recording information in patient records.
- The provider should ensure patient temperatures are measured during their operation in line with national guidance.
- The provider should ensure anaesthetic machine daily safety checks are recorded in the anaesthetic machine log book. However, completion of the anaesthetic machine checks was documented on the patients anaesthetic record.
- The provider should ensure mandatory training compliance meets THC target.
- The provider should consider replacing the difficult intubation trolley to ensure it meets Association of Anaesthetists of Great Britain and Ireland guidelines.
- The provider should replace the shelves in theatre which have exposed wood.

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

Ted Baker

Deputy Chief Inspector of Hospitals (London and the South)

Overall summary

Summary of findings

Horder Healthcare is the provider for The Horder Centre (THC), an independent provider of surgery and outpatient services.

The centre mainly undertakes elective orthopaedic procedures and a small amount of procedures for the relief of pain, for example epidurals (a pain relieving medicine injected into the back).

The centre undertakes a variety of orthopaedic operations including, hip replacements, knee replacements, foot surgery, ankle surgery, shoulder surgery and hand surgery.

Surgery is only performed on patients aged 18 years and over.

There were 5,456 inpatient and day case episodes of care recorded at the centre between October 2015 and September 2016, of these 94% were NHS funded and 6% were other funded.

Forty five percent of all NHS funded patients and 55% of all other funded patients stayed overnight at the hospital during the same reporting period.

The most common procedure undertaken in this period was major hip procedure, which accounted for 17% of all procedures. Major knee procedure was the second most commonly performed procedure and accounted for 13% of all procedures.

There are 42 single inpatient bedrooms with en-suite facilities, a gym for patient use, a discharge lounge and three pre-assessment rooms.

There are three laminar flow theatres (a system that circulates filtered air to reduce the risk of airborne contamination) with a recovery area and a separate 16 bed day care unit.

There is also a therapy garden, which has been developed for the use of patients.

In addition, there is a theatre sterile supply unit (TSSU) that is also located alongside the theatres. This is used to clean and sterilise all the hospital's surgical instruments.

The diagnostic imaging services is managed by Medical Imaging Partnership (MIP) a separate company, under a service level agreement (SLA) and therefore not included as part of this inspection.

The outpatient department had 17,167 total attendances in the period October 2015 to September 2016, which is an average of 1,406 a month. The majority of appointments were funded through the NHS accounting for 98% with the other 2% being insured or self-funded.

Referrals are accepted for the outpatient and diagnostic imaging departments for adults above the age of 18 only. The outpatient department had six consulting rooms and one treatment room. The physiotherapy department had five clinical rooms, four curtained cubicles and a gym/ studio space over two floors. There were also three pre-assessment consultation rooms and a large room used for 'Joint School.'

The outpatient physiotherapy service operated between 8am and 8pm Monday to Thursday, 8am to 6pm on Fridays and 8am to 12:30pm on Saturdays.

The outpatient facilities focussed on elective care with defined operational hours. The department opens from 7:30am to 6:30pm Monday to Friday. These hours were extended as and when required. The outpatient service specialises in orthopaedics, accounting for 88.1% patients. Pain and rheumatology patients accounted for the other 11.99%.

We visited all clinical areas during our inspection. We spoke with and observed the care given by more than 34 members of staff including nurses, doctors, allied health professionals, administrative staff and the executive team. We spoke with ten patients and received five patient comment cards with feedback from patients who had received care at the hospital. We reviewed 15 sets of patient records and a variety of data for example, meeting minutes, policies and performance data.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17th January 2017.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Outstanding** ☆	Overall, we rated surgery services as good for safe and well led and outstanding for effective, caring and responsive. We found that: Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Staff with the necessary clinical knowledge investigated incidents appropriately. Decision making about the care and treatment of a patient was clearly documented. Record keeping was comprehensive. Treatment and care was generally provided in accordance with the National Institute of Health and Care Excellence (NICE) evidence-based national guidelines. A multidisciplinary approach to care was evident throughout all care pathways. Patient outcomes and patient satisfaction were better than national averages. Leadership was good and staff told us about being supported and enjoyed being part of a team. There was evidence of multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients. Feedback from patients was continually positive about the way staff treated people. We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff. There were effective systems to assess and respond to patient risk. We observed staff recognised and responded appropriately to any deterioration in the condition of patients. There were systems, processes and standard operating procedures for example, in infection control that were reliable and kept patients safe. Patients had comprehensive assessments of their needs and their care and treatment was regularly reviewed and updated.

Summary of findings

Patients who used the service were actively involved in the way the service operated
However we also found:
Patient temperatures were not measured in theatres in line with national guidelines.
Gaps were found in the anaesthetic machine log books and it was not documented when the theatre was closed. However, evidence of the checking of anaesthetic machines was documented on the patients anaesthetic record which provided assurances that the safety checks were undertaken.
Mandatory training compliance was below THC target.
The difficult intubation trolley in theatre did not meet the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society guidelines.
There were shelves in theatre with exposed wood, which could pose an infection control risk, as they could not be cleaned effectively.

Outpatients and diagnostic imaging

Good

Overall, we rated the outpatients and diagnostics service as outstanding for caring, good for safe, responsive and well led; effective was inspected but not rated.
We found that:
Safety concerns were identified and addressed. Staff were clear with regards to the process to report incidents. Staff were fully aware of the duty of candour regulation.
There were good infection control procedures in place and the areas were generally visibly clean and well organised. However, we found some areas did not fully comply with the Health Building Notes for flooring and chair covers, although risks were minimised as far as possible.
Records were accessible and completed accurately.
Staffing levels were appropriate for the service provision with minimal vacancies. Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
Consent was obtained before care and treatment was given. Safeguarding systems were in place and staff knew how to respond to safeguarding concerns.

Summary of findings

Staff had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. Although the Advance Decisions (AD) policy needed to use current guidance and the recording of AD in patient records was not embedded.
There were systems to ensure that services were able to meet individual patient needs, for example, for patients living with dementia.
Services were tailored to meet the needs of patients offering flexibility, choice and continuity of care.
The department went above and beyond to ensure patients could access the right care at the right time.
Person centred pathways supported people with multiple and complex needs.
The learning needs of staff were understood. Staff at all levels were supported to participate in training and development.
Multi-disciplinary teams worked well together to provide effective care.
Referral to treatment times were in line with the national average and appointments could be made easily and quickly if required.
Complaint information or how to raise a concern was readily available for patients. Complaints and concerns were always taken seriously and responded to in a timely manner.
Patients were positive about the way staff treated them in all areas. They were involved in decisions about their care and treatment.
Staff felt able to raise concerns to a leadership team that were visible and approachable. Staff were aware of the values and vision for the hospital. There was good staff satisfaction and staff felt supported and valued. There was a strong culture of team working and support across the areas we visited.

Summary of findings

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Outstanding ☆

The Horder centre

Services we looked at
Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to The Horder Centre

The Horder centre is operated by Horder Healthcare.The Horder Centre (THC) is part of Horder Healthcare. THC was founded in 1954 as a charity.

Services provided currently include orthopaedic, reconstructive and total hip, knee and shoulder replacement, physiotherapy, rheumatology, hand therapy, spinal surgery and chronic pain services. A full diagnostic service is provided on site by Medical Imaging partnership with MRI, Ultrasound and X-ray facilities available.

THC is part of the Specialist Orthopaedic Alliance (SOA) leading on orthopaedic service redesign as part of the national Vanguard project for NHS England. THC has undergone a complete refurbishment and redevelopment programme over the last eight years to create a therapeutic environment to aid patient recovery ensuring the flow of services within the building matches the patient pathway. THC has a mix of 96% NHS patients who have chosen THC through NHS Choices and the remainder are privately insured or self-funding.

The registered manager is the Director of Clinical Services who has been in post since April 2008 and held the Registered Manager role since April 2009.

The accountable officer for controlled drugs (CDs) is The Clinical Governance Manager.

Our inspection team

The team that inspected the service comprised two CQC inspectors, and specialist advisors with expertise in theatre management, nursing, a surgeon and a radiographer. The inspection team was overseen by Vanessa Ward, Inspection manager.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the comprehensive announced part of the inspection on 17 January 2017. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Information about The Horder Centre

The centre mainly undertakes elective orthopaedic procedures and a small amount of procedures for the relief of pain, for example epidurals (a pain relieving medicine injected into the back).

The centre undertakes a variety of orthopaedic operations including, hip replacements, knee replacements, foot surgery, ankle surgery, shoulder surgery and hand surgery.

Surgery is only performed on patients aged 18 years and over.

There were 5,456 inpatient and day case episodes of care recorded at the centre between October 2015 and September 2016, of these 94% were NHS funded and 6% were other funded.

Summary of this inspection

Forty five percent of all NHS funded patients and 55% of all other funded patients stayed overnight at the hospital during the same reporting period.

The most common procedure undertaken in this period was major hip procedure, which accounted for 17% of all procedures. Major knee procedure was the second most commonly performed procedure and accounted for 13% of all procedures.

There are 42 single inpatient bedrooms with en-suite facilities, a gym for patient use, a discharge lounge and three pre-assessment rooms.

There are three laminar flow theatres (a system that circulates filtered air to reduce the risk of airborne contamination) with a recovery area and a separate 16 bed day care unit.

There is also a therapy garden, which has been developed for the use of patients.

In addition, there is a theatre sterile supply unit (TSSU) that is also located alongside the theatres. This is used to clean and sterilise all the hospital's surgical instruments.

We visited all clinical areas during our inspection. We spoke with more than 10 members of staff including nurses, doctors, allied health professionals, administrative staff and the executive team. We spoke with five patients and received five patient comment cards with feedback from patients who had received care at the hospital. We reviewed 10 sets of patient records and a variety of data for example, meeting minutes, policies and performance data.

Activity (Oct 15 to Sep 16)

There were 5,456 inpatient and day case episodes of care recorded at THC in the reporting period, of these 94% were NHS funded and 6% were other funded.

The ten most commonly performed surgical procedures were major hip procedures 932, major knee procedures 716, reconstruction knee procedures 702, major pain procedures 485, intermediate knee procedures 339, complex pain procedures 309, intermediate foot procedures 188, major shoulder and upper arm procedures 178, minor hand procedures 169, intermediate shoulder and upper arm procedures 143.

THC had 100% completion rate of validation of professional registration for doctors and dentists working or practising under rules or privileges in the reporting period, and 100% completion rate of validation of professional registration for inpatient nurses in the same reporting period.

The inpatient department at the hospital there was a ratio of nurse to health care assistant of 1 to 1.03 for inpatient nurses at THC. The bank to agency ratio is 1 to 9.9. For inpatient health care assistants at the hospital the bank to agency ratio is 1 to 12.

No whistleblowing concerns have been reported to CQC in the reporting period (Oct 15 to Sep 16).

Sickness rates for nurses in theatre departments were higher than the average of other independent acute hospitals we hold this type of data for from Oct 15 to Jun 16 of the reporting period, except for in Oct 15, Nov 15 and Jun 16. Sickness rates for operating department practitioners and health care assistants in theatre departments were higher than the average of other independent acute hospitals we hold this type of data for from Oct 15 to Jun 16 of the same reporting period, except for in Oct 15 to Dec 15.

The NHS Friends and FamilyTest is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The latest data for all patients between July and December 2015 showed the centre had consistently high scores (greater than 98%) and the response rates varied between 25% and 64%. The response rates for this period were the same as, or better than the average response rates for NHS patients in England.

Summary of this inspection

THC has received 51 items of rated feedback on the NHS Choices website in the reporting period, one respondent was likely to recommend and 50 respondents were extremely likely to recommend.

CQC received one complaint about THC in the reporting period. The provider received 24 complaints in the reporting period. No complaints have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period. The assessed rate of complaints (per 100 inpatient and day case attendances) is 0.42.

THC had 4 FTE posts vacant for inpatient nurses giving a vacancy rate of 24% and 1.72 FTE posts vacant for inpatient health care assistants giving a vacancy rate of 11%. There were 23 FTE posts vacant for other staff giving a vacancy rate of 8%.

The rate of inpatient nurse turnover at THC was 29% in the reporting period, a decrease of 19% from the previous reporting period. The rate of inpatient health care assistant turnover was 11% in the same reporting period, a decrease of 7% from the previous reporting period. The rate of other staff turnover was 21% in the same reporting period, a decrease of 15% from the previous reporting period.

Track Record on Safety (Oct 15 to Sep 16)

Two serious injuries were reported in the period. This number of serious injuries is not high when compared to a group of independent acute hospitals which submitted performance data to CQC. It is still important to understand how the provider has learned from those incidents and what is being done to prevent reoccurrence.

There were a total of 381 clinical incidents in the reporting period. Out of 381 clinical incidents 91% (346 incidents) occurred in surgery or inpatients and 4% (15 incidents) occurred in other services. The remaining 5% of all clinical incidents occurred in outpatient and Diagnostic Imaging services (20 incidents). The hospital reported 0.3% of all incidents[1] as severe or death. The assessed rate of clinical incidents in surgery, inpatients and other services (per 100 bed days) is higher than the rate of other independent acute hospitals we hold this type of data for in two quarters.

THC had 95% Venous thromboembolism (VTE) screening rates with 18 incidents of hospital acquired VTE or pulmonary embolism in the reporting period.

There were three infections in total at THC within the reporting period. The rate of infections during primary knee arthroplasty procedures was below the rate of other independent acute hospitals we hold this type of data for. The rate of infections during revision knee arthroplasty was 1.8 and revision knee arthroplasty was 5.88. There were no surgical site infections resulting from primary hip arthroplasty and other orthopaedic and trauma procedures.

There were 24 cases of unplanned transfer of an inpatient to another hospital in the reporting period .The assessed rate of unplanned transfers (per 100 inpatient attendances) is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

There were eight cases of unplanned readmission within 28 days of discharge in the reporting period. The assessed rate of unplanned readmissions (per 100 inpatient and day case attendances) is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

Summary of this inspection

THC Patient Led Assessments of the Care Environment (PLACE) scores were the same or higher than the England average for:

•Cleanliness (98%)

•Condition Appearance and Maintenance (94%)

•Dementia (82%)

•Disability (82%)

•Food (96%)

•Organisational Food (94%)

•Privacy, Dignity and Wellbeing (96%)

•Ward Food (97%)

Services provided at the hospital under service level agreement:

Critical care level 2/ 3

Dietetics

General waste disposal

Hand therapy

Hazardous waste disposal

Maintenance water

Medical equipment service and maintenance

Medical Gas Services

Occupational health service

Pathology including blood transfusion, biochemistry, haematology and microbiology

Physician cover

Pharmacy governance

Radiation protection

Resident medical officer

Resuscitation officer Horder Healthcare

Resuscitation support & training

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Incidents were reported, investigated and learning evidenced. Reports were communicated to all staff.

Patients were cared for in a visibly clean environment that was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored. There were no outbreaks of serious infection reported.

There were processes for assessing and responding to patient risk.

The service had enough staff with the skills and experience to care for the number of patients and their level of need.

Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use. However there was room for improvement with anaesthetic machine daily safety checks.

Staff demonstrated good medicines storage, management and administration.

Are services effective?

Outstanding

We found care and treatment reflected current national guidance. There were formal systems in place for collecting comparative data regarding patient outcomes. However, the provider should ensure patient temperatures are measured during their operation in line with national guidance

Staff worked with other health professionals in and out of the hospital to provide services for patients.

Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.

There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day. There was comprehensive assessment of patient needs. This included clinical needs, physical health, nutrition and hydration needs. Patients received adequate pain relief.

Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions,

Summary of this inspection

most staff were able to explain what steps to take to ensure relevant legal requirements were met. However, the provider should review it's policy on the use of Advance Decisions (AD) and ensure that staff are accurately recording information in patient records.

There was a proactive audit programme that included national, corporate, hospital and departmental audits. Results were shared throughout the hospital and collated to identify themes.

Are services caring?

Outstanding ☆

There was a strong, visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity.

Staff provided sensitive, caring and individualised personal care to patients.

Staff supported patients to cope emotionally with their care and treatment as needed.

Patients commented positively about the care provided from all staff they interacted with.

Patients felt well informed and involved in their procedures and care, including their care after discharge. Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment.

Families were encouraged to participate in the personal care of their relatives with support from staff. We observed patients treated with compassion, care and dignity.

Patient feedback was positive and staff demonstrated commitment to continuous improvement.

THC participated in the NHS friends and family test for NHS-funded patients. Data between April – September 2016 showed consistent scores of 99%-100%, which ranked in the top five providers each month. This meant nearly all patients would recommend the centre.

Are services responsive?

Outstanding ☆

There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs. For example those with spiritual needs, patients whose first language was not English, or support for people living with dementia or learning disabilities.

THC was part of the Specialist Orthopaedic Alliance (SOA) leading on orthopaedic service redesign as part of the national Vanguard project for NHS England. THC had undergone a complete

Summary of this inspection

refurbishment and redevelopment programme over the last eight years to create a therapeutic environment to aid patient recovery ensuring the flow of services within the building matches the patient pathway.

The services were delivered in a way that met the needs of the local population and allowed patients to access care and treatment when they needed it. Waiting times, delays and cancellations were minimal and well managed.

Patients told us staff were responsive to their needs. Complaints management was a priority in the hospital. The process was transparent and open with learning communicated across the hospital.

Are services well-led?

Good

There were clear organisational structures and roles and responsibilities. The senior management team were highly visible and accessible across the hospital.

Staff described an open culture and said managers were approachable at all times. Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.

There were good governance, risk and quality systems and processes that staff understood. The committee structure supported this with reports disseminated and discussed appropriately.

Staff from all departments had a clear ambition for their services and were aware of the vision of their departments. Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services.

The hospital had a risk register which was reviewed at the governance committee meetings.

The management team had an understanding of the Workforce Race Equality Standard (WRES) as there is a national requirement to produce key data relating to race quality in the workplace. They had collected data which they currently held, for example the numbers of staff from black and ethnic minority groups.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Surgery

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

Are surgery services safe?

Good ●

We rated safe as good.

Incidents

- The reporting period referred to throughout the safe section is between October 2015 and September 2016 unless otherwise stated.
- The Horder Centre (THC) did not report any never events in the reporting period. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- THC reported one unexpected death in the reporting period.
- THC provider reported two serious injuries in the reporting period. This number of serious injuries was not high when compared to a group of independent acute hospitals, which submitted performance data to the CQC.
- There were 381 clinical incidents reported in the reporting period, of these incidents 91% occurred in surgery or inpatients. The provider data showed that 60.4% of these incidents resulted in no harm, 34.9% in low harm, 4.5% in moderate harm and 0.3% of all incidents as severe or death.
- There was a Horder Healthcare (HH) Incident Reporting and Risk Management Database Policy and Procedure, which was in date. The policy referenced national guidance for example NHS England SI Framework- Never Event Policy and Framework- March 2015.
- THC used an online software system for reporting incidents. Staff could describe the process for reporting incidents, and gave examples of times they had done this. All staff we spoke with had confidence in the incident reporting process.
- THC had a system, which ensured staff learned from incidents to improve patient safety. The head of departments (HODs), such as the ward manager or theatre manager, investigated all incidents. Staff told us they received feedback with any learning from incidents at ward or theatre meetings. We saw copies of theatre and ward meeting minutes, which reflected this. Staff were able to give us examples of changes to practice following incident learning. A recent example of this included the documentation of the discussion between the anaesthetist and patient regarding the type of anaesthetic the patient would have. This followed an incident regarding consent for anaesthetic.
- Incidents that were more significant and any trends in incident reporting, such as readmissions or returns to theatre were discussed at the clinical governance meetings. We saw meeting minutes, which confirmed this.
- Staff knew about their duty of candour (DoC) responsibilities under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which was introduced in November 2014. “The duty of candour is a regulatory duty that

relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person."

- Staff gave us examples of incidents, which triggered DoC, such as complications of surgery. Staff could describe their responsibilities relating to DoC.
- THC did not carry out specific morbidity and mortality review meetings, this was due to the low numbers of patients treated and the resulting low numbers of patients who would fall into this category. However, the chair of the medical advisory committee (MAC) told us that all deaths and complications were discussed at the quarterly MAC meetings and we saw meeting minutes, which confirmed this.

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

- The NHS safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- Patients identified at risk were placed on an appropriate care plan and were monitored more closely by staff. For example, if a patient was at risk of having a fall a motion sensor mat would be placed on their bed, this notified staff electronically when the patient had got out of bed.
- THC reported 15 incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) between October 2015 and September 2016 in the reporting period. THC fully investigated each case using root cause analysis (RCA). We saw copies of RCAs for the last three cases of PE. All RCAs showed staff calculated the risk of VTE correctly and gave appropriate prophylaxis, such as anti-embolism stockings, in accordance with the hospital's "anticoagulation policy". All RCAs showed the PEs could not have been prevented. However, one RCA identified the need for the importance of maintaining an accurate record of what steps had been undertaken in theatres to prevent VTEs and PEs. This was discussed with the theatre staff at their weekly meeting.
- We saw that safety thermometer data was displayed on the ward for example, at the time of our inspection it had been 16 days since the last patient fall. This meant staff and patients were able to see this information.

Cleanliness, infection control and hygiene

- THC reported no infections of Meticillin-resistant Staphylococcus aureus (MRSA) or meticillin-sensitive Staphylococcus aureus (MSSA) in the reporting period. There was one reported case of Escherichia coli or Clostridium difficile (C. diff) in the same period.
- There were three surgical site infections (SSIs) in the reporting period, two of these related to knee surgery and one related to hip surgery.
- The rate of infections during primary knee arthroplasty (the surgical reconstruction or replacement of a joint) procedures was below the rate of other independent acute hospitals we hold this type of data for.
- There were no surgical site infections resulting from primary hip arthroplasty and other orthopaedic and trauma procedures.
- Pre-assessment staff told us the centre swabbed all patients for MRSA except for day case procedures, who were risk assessed and swabbed if deemed to be high risk. We saw in patients' records completed pre-operative questionnaires, which included completed risk assessments.
- Ward staff described to us using aseptic techniques when changing a dressing using a non-touch technique to avoid any cross infection. This was in line with The National Institute for Health and Care Excellence (NICE) guidance (QS49).
- We observed that NICE guideline CG74, Surgical site infection: Staff in the theatre environment followed prevention and treatment of surgical site infections (2008) was followed. This included skin preparation and management of the post-operative wound.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or

disability and general building maintenance. In the most recent PLACE, assessment for cleanliness the hospital scored 98%, which was equal to the England national average.

- We saw that all clinical areas were visibly clean and tidy. We saw "I am clean stickers" on equipment to provide staff with assurances that, equipment was cleaned and ready to use.
- We saw copies of daily, weekly and monthly cleaning schedules in theatres and these were fully completed.
- There was an annual deep cleaning programme within theatres, which was undertaken by an external company and we saw evidence of this.
- We saw environmental audits were undertaken these were based on the 49 elements of the national specifications for cleanliness (NSC) in the NHS. We saw environmental audits had been undertaken on Dufferin ward (February 2016) and the day surgery ward (May 2016) there were action plans to address areas of non-compliance which had been completed. The NSC require 95% compliance to pass, data indicated that on average audits undertaken at the centre showed 97% compliance. This demonstrated the centre had assurances around cleanliness.
- THC's annual infection prevention (IPC) report for 2016 detailed activities to ensure the hospital met the requirements of the Department of Health: Code of Practice on the prevention and control of infections and related guidance. The report set out what audits would be undertaken in relation to IPC, systems to manage and monitor the prevention and control of infection, maintain a clean and appropriate environment, ensure appropriate use of antimicrobials and ensure all staff were fully trained in the IPC processes.
- All members of staff we saw in clinical areas were bare below the elbows to prevent the spread of infections in accordance with national guidance. Data supplied by the provider showed that in an audit undertaken in September 2016, 98% of staff were bare below the elbows. This showed that all staff were consistently bare below the elbows.
- Alcohol hand sanitiser and clinical wash hand basins were available in all clinical areas.
- We saw that all clinical wash hand basins, including those in patient bedrooms on Dufferin Ward, were compliant with the Department of Health's Health Building Note 00-09.
- We saw staff wash their hands and use hand gel appropriately, for example before and after patient contact. This was in line with the world health organisation's (WHO) "Five moments for hand hygiene".
- Monthly hand hygiene audits were undertaken, the audit for September 2016 showed 89% compliance.
- We saw personal protective equipment (PPE), readily available in the ward and in the theatres alongside a poster advising of correct PPE procedures. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.
- We saw theatre staff dressed appropriately in scrub suits and designated theatre shoes. Staff were not permitted into any clinical areas within the theatre department in outdoor clothing. Staff either changed clothes or wore a clean gown over their theatre clothes if they needed to visit other areas within the centre. We saw that all staff followed this policy.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment between patients, we witnessed staff using these.
- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. The clinical waste unit was secure.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked 12 sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability. We saw in theatres, the sharps bins where on wheels, this meant the bin could be moved to the patient and sharps could be disposed of immediately.
- THC had three operating theatres all had laminar flow theatre ventilation (a system that circulates filtered air to reduce the risk of airborne contamination), which was

best practice for ventilation within operating theatres, and particularly important for joint surgery to reduce the risk of infection. Records were kept of the maintenance and ventilation revalidation results, this was in line HTM 03-01 2007.

- The computer keyboards within theatres were wipeable, which reduced the risk of spreading germs.
- There was access to a microbiologist for advice 24 hours a day seven days a week.
- THC had a system for managing the risk of Legionnaires disease. Legionnaire's disease is a lung infection caused by Legionella bacteria. Legionella bacteria is spread when water supplies become contaminated with the bacteria which is more likely in larger, more complex water systems such as those found in hospitals.
- The facilities manager explained that the centre manages the Legionella risk by flushing taps throughout the hospital daily and testing the water for Legionella bacteria quarterly, this was undertaken by an external contractor. The facilities manager gave us examples of when water samples had tested positive for Legionella and described the action that was taken which was appropriate.
- Flooring throughout the ward and theatres was compliant with guidelines for effective cleaning in line with HBN 3.110 'There should be coving between the floor and the wall to prevent accumulation of dust and dirt in corners and crevices.'
- We saw in theatres some shelves were damaged and wood was exposed. This meant they could not be cleaned effectively and may pose an infection control risk. We raised this with the theatre manager and after the inspection, they assured us that replacement shelves had been ordered.
- The minutes of the Infection Prevention and Control (IPC) meetings were kept on file by the Infection Prevention Control Co-ordinator (IPCC) and were available for all staff to read.
- The IPC met with the Medical Advisory Committee (MAC) quarterly and reported on any issues regarding infection prevention and control. We reviewed minutes of the MAC meetings and saw mixed levels of input from the IPC, due in part to the recent employment of a new IPCC.
- THC had recently employed a full time Infection Prevention and Control Coordinator (IPCC) who provided leadership for infection prevention and control within the centre. The IPCC was also responsible for the surveillance, analysis and reporting of infections and conducting training for staff in IPCC policies and practice.

Environment and equipment

- We checked two resuscitation trolleys, one in theatres and one on Dufferin Ward. On both trolleys, all equipment and drugs were within their use-by dates .We also saw checklists for both trolleys showing evidence staff checked the trolleys daily. This provided assurances emergency equipment was safe and fit for purpose.
- We checked the anaesthetic machines in all theatres and anaesthetic rooms and saw logbooks showing evidence of gaps in the daily checking process. For example, the logbook in theatre showed four gaps for the week beginning 19 December 2016, two gaps for the week beginning 12 December 2016 and four gaps for the week beginning 05 December 2016.This did not provide assurances that the anaesthetic machines had undergone the required daily safety check. This also contravened the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. We raised this issue with the theatre manager, and after the inspection, we were told staff would confirm the checks had been undertaken and documented at the morning team briefing. In addition, compliance would be monitored via a monthly audit.
- Theatres had a difficult intubation (placing a breathing tube in the windpipe) trolley, which did not meet the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. However, there was a difficult intubation trolley and we saw records that the equipment was checked monthly and was ready to use in the event of an emergency.
- There were emergency 'grab bags' available for the transfer of patients between recovery and the ward. These contained emergency equipment for use if a patient becomes unwell during a transfer. Bags were checked daily to ensure they were ready for use and we saw completed records, which confirmed this.

Surgery

- All patients were given a warming blanket prior to the start of their operation. These blankets stayed warm for 16 hours and prevented patients from becoming cold during their operation. Feedback from patients regarding these was positive.
- Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut. There was a centre generator that was tested monthly; this ensured there was a backup supply of electricity if the main electricity supply failed and we saw records that confirmed this.
- We saw that electrical safety checking labels were attached to electrical items showing that it had been tested and was safe to use. We checked 18 pieces of electrical equipment and all had been tested within the last 12 months.
- We saw records confirming daily equipment checklists were undertaken within theatres. This ensured all necessary equipment was available for use.
- There was a freezer in theatres that was used for the storage of live bone for donation. We saw there were daily checks to ensure the temperature was within a safe range. Records confirmed these checks were undertaken. In addition, there were instructions on what action staff should take if the temperature was outside a safe range; staff confirmed this process verbally to us.
- We saw Health and Safety Control of Substances Hazardous to Health were stored in line with Health and Safety Executive guideline SR24.This ensured safe storage of substances, which could cause harm to staff and prevented unauthorised access.
- We checked over 20 consumable (disposable equipment) items and all were within their expiry date, which showed they were safe to use.
- On Dufferin Ward, we saw sufficient equipment to maximise patients independence while they recovered from orthopaedic surgery. This included walking frames, crutches, wheelchairs, raised toilet seats and walk in showers.
- An external contractor undertook the servicing of equipment. The centre maintained an asset register with details of equipment servicing. This meant there was a system, which ensured equipment was appropriately serviced and maintained.
- We saw in theatres that there was an effective system in place to ensure the recording of medical implants used. This was in accordance with the Medical Devices Regulations 2002. A medical implant is a device intended to be either totally introduced into the body or to be partially introduced into the body through surgery and to remain there for at least 30 days.
- In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients' operations. This ensured no items were left behind during surgery and was in line with the Association for Perioperative Practice (AfPP) guidelines.
- The staff we spoke with confirmed they had access to the equipment they required to meet peoples' care needs.
- The centre had an onsite theatre sterile supply unit (TSSU) for the sterilisation of instruments. The service offered a two-hour turnaround time on instruments. The TSSU used an electronic traceability system to enable the tracking and tracing of instruments for quality assurances purposes.

Medicines

- The centre had a medicine policy, which was in date and referenced national guidance for example General Medical Council (2013), Good practice in prescribing and managing medical devices, and Nurse & Midwifery Council (2006), Standards for proficiency for nurse and midwife prescribers.
- We saw patients had their weight and height recorded on their drug chart, this ensured the correct dosage of medicine was given.
- There was a pharmacy department within the centre, which supplied medicines and medicine support to the ward and theatres.
- There was a service level agreement (SLA) in place between Horder Healthcare and a local NHS trust, which was reviewed every three years.

Surgery

- The pharmacy team provided by the NHS trust used the existing pharmacy department area within the centre.
- An onsite pharmacy service was provided Monday to Friday between 9:30am and 1pm and between 1:30pm and 4:30pm. Outside of these hours, the resident medical officer (RMO) could administer medicines from the out-of-hours medicines cupboard.
- We checked controlled drugs (CDs) in theatres, recovery and on Dufferin Ward. Controlled drugs are medicines liable for misuse that require special management. We saw the CD cupboards were locked in all three areas. Only authorised staff could access CDs using a key. We saw CD keys were kept securely within a locked key press this required a number combination to assess and this number was changed monthly. We checked the CD registers in all three areas and found two members of staff had signed for all controlled drugs. This was in line with national standards for medicines management. We randomly checked the stock level of drugs in all three areas and saw the correct quantities in stock according to the stock list, and that all were in date.
- The centre undertook regular CD audits, which monitored the documentation and storage of CD's. We reviewed an audit undertaken in theatres in august 2016 which showed on one occasion CD's received had not been signed for in the order book. The action was to remind staff of the need to document all CD's received at the daily team briefing.
- We saw the CD register did not include all stages of the medicine administration, and the amount of the medicine used and wasted. We raised this with managers at the centre who responded quickly and ordered the updated version of the register.
- We checked the drugs fridges in the anaesthetic room's recovery and Dufferin Ward. We saw that fridge temperatures in all areas were within the expected ranges. We saw records in all areas, which showed staff, had checked the fridge temperatures daily. All temperatures recorded were within the expected ranges, and there were no gaps on the checklist. This provided assurances the centre stored refrigerated medicines within the recommended temperature range to maintain their function and safety.
- There was a completed daily checklist for monitoring the ambient temperature on the wards and theatres. This ensured that medicines stored at room temperature remained within the manufacturer's indicated temperature range.
- The centre undertook regular medicines security audits in theatres, day surgery unit and Dufferin Ward. We saw after the audit and action planned was created to address any issues raised in the audit. The action plan had a nominated staff member whose responsibility it was to ensure the action plan was completed.
- An audit undertaken in June 2016 on Dufferin ward showed 82% compliance in relation to the correct documentation of medicines given to patients to take home. There was a completed action plan, which addressed areas of non-compliance.
- The centre undertook a prescribing and medicines reconciliation (MR) audit in May 2016. The National Institute for Health and Care Excellence (NICE) guideline NG5 states MR should be undertaken within 24 hours of the patient's admission. The audit showed that 70% of patients had MR completed within the time frame. Medication reconciliation is matching the medicines the patient should be prescribed to those they are actually prescribed. We noted that MR had been completed on all drug charts we reviewed however we did not assess the timeliness of the MR.
- The centre undertook an inpatient medicines management audit in August 2016.This audit showed that 100% of medicines were signed for to show they had been administered or a code documented when they were not given. This demonstrated staff documented when medicines were given to patients or a reason recorded when they were not given.
- Staff reported having good access to pharmacists when advice was required and adequate access to medicines. Pharmacy technicians undertook twice-weekly reviews of stock levels and ordered replenishments.
- Patient allergies were clearly noted on their paper notes, medication chart and on their identity band, which alerted staff to their allergy.

- We checked eight oxygen cylinders all were secured to a wall labelled and within date. This meant cylinders were kept securely, were clearly labelled as to their contents and were safe to use.
- The resident medical officer (RMO) prescribed medicines for patients to take-out (TTO). The pharmacy team reviewed TTO prescriptions daily to provide oversight. We saw that nurses counselled patients on TTO drugs at discharge.
- We reviewed the centres prescription pad records and these were recorded correctly. All prescription pads were kept in a locked cupboard. We saw evidence of the prescribing pad log, which was up to date, showing serial number, date and time when the prescription pads were last used.

Records

- We reviewed ten patient records and saw evidence of clear documentation, with no loose records. Staff had signed and dated all entries. This was in-line with guidance from the General Medical Council. All ten patients had care plans that identified all their care needs. We saw staff had fully completed all five care plans. Records were legible, accurate and up to date.
- Patient records were kept at the staff station, which was always occupied by a member of staff. This prevented unauthorised access to confidential patient data. After discharge, the centre held patient records in securely on the centre site. This allowed centre staff to easily access patient records, for example if a patient was readmitted to the centre.
- We saw the theatre records section of care plans were clear and safety checks documented to ensure safe surgery and treatment was undertaken.
- THC used a number of patient pathway documents, which followed the path the patient took through a specific surgical episode such as a total hip and knee replacements. This meant specific risks associated with these procedures were assessed. In addition, in meant all relevant information was in one place together which made finding relevant information easier.
- The centre undertook monthly records audits, which were comprehensive and looked at all aspects of documentation from pre admission to discharge. For example, in July 2016 the audit showed that 100% of patients had completed a pre procedure medical questionnaire. This demonstrated that the provider ensured record keeping was complete and relevant risk assessment had been undertaken.

Safeguarding

- There were no safeguarding concerns reported to CQC in the reporting period.
- The matron was the centre lead and first point of contact for any safeguarding concerns raised these would then be escalated to the Director of Clinical Services. The matron had undertaken level 3 adult and child safeguarding training.
- The ward manager of Dufferin ward had also completed level 3 adult and child safeguarding training.
- One hundred percent of day surgery staff and 95% of ward staff had up to date adult safeguarding training this was better than the Horder Healthcare (HH) target of 90%.
- Eighty-eight percent of theatre staff had up to date adult safeguarding training, this was worse than the HH target of 90%.
- Ninety-seven percent of day surgery staff and 95% of ward staff had up to date children safeguarding training this was better than the HH target of 90%.
- Eighty-eight percent of theatre staff had up to date children safeguarding training, this was worse than the HH target of 90%.
- There were flow charts in each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.

Mandatory training

- Human Resources were responsible for developing and maintaining the e-Learning programme and advertising the courses in the weekly operational bulletin. They also had oversight of completion records so could inform managers of individuals who were falling behind expectations, or operational managers if a whole department was.

- We saw the training records for staff, which were included within their appraisal. If staff were non-compliant with their training, it would be highlighted at their appraisal.
- Managers were able to show us up to date training records of all their staff, from these it was easy to identify who was not complainant with their training. Staff received emails from their managers when their training was due to expire. This meant staff had enough time to book the required training before it expired.
- There was a combination of on line learning and face-to-face learning. Staff confirmed they were given enough time and support to complete their mandatory training.
- Eighty-four percent of all surgical staff had up to date mandatory training, which was worse than the HH target of 90%.
- Managers told us there was a backlog of mandatory training as the majority of staff's training expired at the same time. The majority of staff had mandatory training booked in the near future. This provided assurances that there was a plan in place, which ensured staff were compliant with mandatory training.

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

- Patient's risks were assessed and monitored at pre-assessment, and checked again before treatment. These included risks about mobility, medical history and skin damage. This ensured they were medically fit to undergo their operation and their condition had not changed since pre assessment.
- THC did not have any level two or three critical care beds. To mitigate this risk, the unit only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.
- Patients completed a preadmission questionnaire to assess if there were any health risks, which may compromise their treatment at the unit. Nurses discussed the health questionnaires with patients in the pre-admission clinics or via the telephone. If staff identified a patient as being at risk, they were not accepted for surgery.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment.
- We reviewed 10 completed WHO checklists and all were fully completed. This meant there was assurance that the safety checks had been undertaken correctly.
- Staff met for a 'team briefing' at the start of each operating list in accordance with the World Health Organisation 'Five steps to safer surgery'. We observed three team briefings, which were comprehensive and discussed each patient to minimise any potential risk to patients. Pre-existing medical conditions and allergies were discussed to ensure the team was informed. Equipment requirements were also discussed and we witnessed surgeons checking the equipment available. The briefings demonstrated that risks were discussed and any potential issues were highlighted.
- Theatres undertook monthly WHO team briefing audits which highlighted the number of on the day cancellations number of order changes to the operating list, clinical incidents reported, equipment issues and environmental issues .For example, the September 2016 audit showed five clinical incidents were reported and there was an issue with the supply of hot water. This showed that any issues were highlighted and could be investigated to prevent a reoccurrence.
- WHO audit findings were shared during theatre staff meetings and daily briefings so learning could be shared and improvements made.
- Staff explained when the operating list was first printed it was done on green paper, if there was a change to the list the list would be re printed on yellow paper and the green lists disposed of. If there was a further change, it would be re printed on red paper and the yellow lists disposed of. In addition, the WHO team briefing would be undertaken again if the list was re printed onto red. This served as a visual reminder to staff there had been changes to the operating list and ensured the most current operating list was being used.

- We saw in patients' records that patients had falls risk assessments this was in line with NICE guideline CG16.
- Staff calculated National Early Warning System (NEWS) scores in line with NICE clinical guidance CG50 and sepsis (infection) recognition. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support.
- The centre undertook a NEWS audit in September 2016, which showed 100% of patients, had a NEWS score calculated and documented every time a patient had their observations undertaken. This gave assurance that patients were having NEWS scores calculated and any changes would be escalated to the nurse in charge and the RMO.
- The centre had a service-level agreement (SLA) with a local NHS centre. This enabled them to transfer any patients who became unwell after surgery and needed critical care support.
- Staff told us any patients who developed complications following discharge could contact the nurses on Dufferin Ward any time, day or night. We saw a copy of the discharge pack given to patients, and this included a 24-hour contact number direct to the ward.
- Centre data showed the centre risk-assessed over 95% of patients for venous thromboembolism (VTE) in the reporting period. We reviewed ten patient records and saw staff had recorded the risk of VTE, and completed all steps of the VTE assessment. This meant the centre had assurances staff always assessed the risk of VTE correctly.
- The RMO undertook twice-daily ward rounds with the nurse in charge of the ward, this meant every patient was reviewed and their care and treatment adjusted as necessary.
- The centre used a communication tool called Situation Background Assessment Recommendations (SBAR), a technique that can be used to facilitate prompt and appropriate communication, for both medical and nursing staff to use when escalating concerns about a patient's condition.
- Staff told us they checked the pregnancy status of all female patients of potential childbearing age on the morning of planned surgery by undertaking a pregnancy test. We saw the results of the test were documented on pre-operation checklist.

Nursing and support staffing

- The centre used the Shelford Dependency tool and a Nurse Hours per patient day (NHPPD) tool, which provided an allowance of 5.5 hours NHPPD for inpatients. The centre acknowledged that this tool did not make individual allowance for each patient's dependency or care needs. Therefore, it was supported by the skills of the nurse in charge who considered these factors simultaneously when assessing nursing requirements. This assessment was completed the day before to ensure the correct staff were planned to be on-duty in line with the safe staffing policy. The tool identified the total nurse hours required and this was then documented against the total number of nurse hours booked to work. The senior nurse on duty reviewed any variances that this identified and made arrangements to ensure the two figures match. The current NHPPD calculation included registered nurses (RNs), care assistants (CAs), and was a 24-hour calculation for example, 5.5 hours per patient per 24-hour period.
- The theatre department staffed operating lists in accordance with The Association for Perioperative Practice (AfPP) guidelines. During our inspection, we reviewed planned staffing rotas, as well as records showing the actual number of staff on each shift. These showed staffing levels met AfPP guidelines on all shifts. Staffing levels were anticipated in advance of planned theatre lists.
- On 1 October 2016, surgery employed 11.3 whole-time equivalent (WTE) theatre nurses and 14.5 WTE operating department practitioners (ODPs) and health care assistants (HCAs).There was one full time post vacant for ODPs giving a vacancy rate of 6%.There was no vacancies for theatre nurses.
- The use of bank and agency nurses in theatre departments was lower than the average of other independent acute centres we hold this type of data for throughout the reporting period.

- The use of bank and agency ODPs and health care assistants in theatre departments was variable in the reporting period. Rates were higher than the average of other independent acute centres we hold this type of data for in February 2016 and April 2016 to June 2016.
- On 1 October 2016, surgery employed 12.9 whole-time equivalent (WTE) inpatient department nurses and 13.3 WTE HCAs. There were four full time posts vacant for inpatient nurses giving a vacancy rate of 24% and 1.72 full time posts vacant for inpatient HCAs giving a vacancy rate of 11%.
- The use of bank and agency nurses in inpatient departments was lower than the average of other independent acute centres we hold this type of data for the reporting period, except for in October 2015 and December 2015.
- The use of bank and agency HCAs in inpatient departments was lower than the average of other independent acute centres we hold this type of data for in the reporting period, except for in October 2015.
- There were daily handovers, one at the beginning of the day and the other towards the end of the day. Each patient had a named nurse, who handed over patients in their care to the new nurse coming on shift. Handovers took place at every shift change. Handovers included important safety information such as pressure area risks. This allowed continuity of safe care. Nurses used handover sheets to provide written information on each patient including allergies and any significant medical history. This ensured staff handed over all relevant information.

Medical staffing

- The centre's resident medical officers (RMOs) provided medical cover 24 hours a day, seven days a week. This ensured nurses could always quickly escalate any issues concerning a deteriorating patient. The RMO also informed the patient's consultant in an emergency so that they could provide consultant-level care. The RMOs work one week on and one week off duty. THC employed one RMO directly and the other RMO was provided under a service level agreement (SLA) with an agency.
- As part of their practicing privileges agreement, consultants had to be available on-call 24 hours a day whenever they had an inpatient under their care in the centre. Staff told us consultants attended promptly to review patients where there were clinical concerns. Practising privileges is a term that is used in legislation when a centre manager grants permission to a medical practitioner to practice in that centre.
- The admitting consultant was responsible for their patients throughout their complete episode of care. If a consultant was on leave, they ensured a fellow consultant of a similar specialty covered. The anaesthetist remained responsible for the patient for the first 24-hours post- surgery and was available in case of any requirement to return to surgery.
- The RMO conducted twice-daily ward rounds with the nurse in charge to ensure patients were safe. The RMO also told us they visited Dufferin Ward in between those times to review patients.
- The RMOs carried out a formal handover. However, we did not see this as there was no change over during our visit.

Emergency awareness and training

- There was Major Incident Team (MIT) who co-ordinated all major incident planning. This included the centre operations manager, facilities manager, information technology network manager, matron and theatre manager among others.
- THC 'Crisis Management Manual' ' included flow charts of actions to be taken in of the event of a major incident which included loss of mains power, gas and water supply, explosion, release of toxic gases, flooding and/or severe storm damage, loss of essential facilities, failure of the medical gas system, pandemic outbreak and fire. The strategic development manager facilitated overall review every six-months.
- THC was a member of the local NHS Centres Trust Emergency Planning Group. There was an agreement in place with this group, which provided support to the centre from local NHS organisations in the event of a major incident.
- We saw that the centre risk register had highlighted out of date on-call process and procedures in the event of an emergency as a potential risk. As a result, they had reviewed and changed the on-call process and procedures and made improvements to direct clinical

and management responses. Including the increase in availability of key senior staff members to ensure an improvement to the balance and safety of responses during an incident.

- A generator would provide supplies to all of the centre in the event of power loss.
- Staff undertook twice-yearly scenario training, this included managing a cardiac arrest. This ensured staff practiced managing emergency situations, which did not occur frequently at the centre but staff had the necessary skills should an emergency happen.

Are surgery services effective?

Outstanding ☆

We rated effective as outstanding.

Evidence-based care and treatment

- Generally, care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines.
- However, we saw in theatres patients' temperatures was not measured and documented in accordance with inadvertent perioperative hypothermia, NICE guidance clinical guideline CG 65.This meant patients could become too hot or too cold and this would not be identified in a timely manner. We raised this issue with the theatre management team who explained they were awaiting the delivery of temperature monitoring. After the inspection, the theatre manager contacted the supplier to arrange urgent delivery.
- In theatres, and in the patient notes, we saw evidence of providing care and treatment in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic liquid.
- We reviewed 10 patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in unit- recognising and responding to deterioration.
- The national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was also in line with NICE clinical guideline CG50.
- We saw in the patient records we reviewed completed venous thromboembolism (VTE) assessments in accordance with NICE clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to surgery.
- Patient notes showed pre-assessment nurses performed pre-operative tests such as electrocardiogram for patients with pre-existing heart conditions. This is in line with NICE guideline NCG45: Routine preoperative tests for elective surgery.
- There were specialist clinical pathways and protocols for the care of patients undergoing different surgical procedures. For example, total hip and knee replacements these were designed to specifically assess risks associated with these operations.
- Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on THC intranet. The centre took part in national audits, such as the National Joint Registry.
- We saw meeting minutes, which confirmed monthly meetings within theatres and the ward, where NICE guidelines and compliance was discussed.
- The Horder Centre (THC) followed evidence based enhanced recovery pathways for hip and knee replacements and participated in enhanced recovery programmes (ERP).
- The ERP aims to improve the experience and wellbeing of people who require surgery. The ERP promotes

health and wellbeing helping patients to return to normal as soon as possible. Research shows that the sooner patients get out of bed, begin to walk and start eating and drinking the quicker they recover.

Pain relief

- We observed that consideration was given to the different methods of managing patient's pain, for example, pain relief patches. Nurses on the medication rounds would ask each patent if they were in any pain and would give prescribed analgesia if necessary.
- The pre assessment lead told us that patients were counselled on pain management as part of the pre assessment process. Patients we spoke to confirmed different pain relief had been discussed at pre assessment. In addition, patients confirmed take home pain relief medicines were also discussed. This meant patients were informed regarding pain relief prior to their procedure.
- The service used a numerical pain assessment scale to monitor patients' pain levels. During routine observations, staff asked patients to rate their pain between one and 10 (one meaning no pain and 10 being extreme pain). We saw pain scores recorded in all ten sets of notes we reviewed.
- All patients we spoke with said their pain was well controlled and staff responded quickly when pain relief was requested.
- We saw potent pain relief was prescribed for the immediate post-operative period when the patient was in recovery. This meant if a patient woke up from the anaesthetic and experienced pain it could be administered to the patient quickly rather than it having to be prescribed.
- There was no dedicated pain team at the centre. However, pain management was discussed at clinical focus groups, which were attended by ward staff, theatre staff, and the matron. For example, at the time of our inspection a trial was underway in the use of pain relief patches for knee replacements. This trial was discussed at the clinical focus group and had consultant and anaesthetist input.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition and if a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician. Ward staff were able to make referrals to dieticians for review when required. Centre data showed that in July 2016, 100% of patients had a nutrition assessment undertaken.
- The centre followed the Royal College of Anaesthetists guidance on fasting prior to surgery. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. Administrative staff phoned patients the day before their surgery to advise them on fasting times. We saw that staff asked patients to confirm the time they last ate and drank before surgery. This ensured the service complied with the Royal College of Anaesthetists guidelines.
- THC data demonstrated that in July 2016 100% of patients had a completed fluid balance chart which showed fluid intake whilst the patient was in theatre. This meant there was a record of the amount of intravenous (into a vein) fluid given during the patients operation.
- Patients undergoing a joint replacement operation were given pre-operative carbohydrate drinks to drink the day before and on the day of their operation, this was in accordance with NICE guideline CG32. Having an empty stomach before an anaesthetic was important because it makes it less likely that food or fluid from the stomach can be regurgitated (come back up), which can be dangerous. Pre-operative drinks are specially formulated to help the body cope with the stress of surgery. They can also make patients feel better after surgery.
- THC data showed that in July 2016, 60% of patients had pre-operative drinks discussed with them at pre-assessment. The patients we spoke to said pre-operative drinks had been discussed with them at pre-assessment. This meant how and when to drink the drinks and the purpose of them had been discussed with the patient.
- The day surgery unit offered hot drinks, water and biscuits to patients before discharge home.

- There was a menu available for patients and all the food was cooked in the centre. Patients told us that the quality and variety of food was good.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2016 scored 97% for ward food and 96% for all food both scored better than the England average.

Patient outcomes

- THC participated in national data programmes including the National Joint Registry (NJR) and the National Patient Reported Outcome Measures programme (PROMS).
- PROMS used patient questionnaires to assess the quality of care and outcome measures following surgery.THC had higher than national average post surgery outcome scores for PROMS for both hip and knee replacements. For the period between April 2016 and September 2016 data published in February 2017 showed THC scored 100% for total hip replacement compared to the national score of 97.5%.The same data showed that THC scored 95.5% for total knee replacements compared to the national score of 94.5%.
- The chair of the medical advisory committee reviewed and monitored individual consultants performance by accessing the NJR. This ensured that each consultants performance was benchmarked and monitored.
- Patient outcomes and patient satisfaction continually exceeded national averages. The chair of the medical advisory committee used patient outcomes to validate and proactively monitor each consultant's performance.
- Medical advisory meetings were focused on reviewing and monitoring patient outcomes and ways they could be improved.
- All adverse events / infection control surveillance and key performance indicators were documented in a quarterly clinical governance report (CG) and reviewed at the quarterly CG committee and the summary shared with the medical advisory committee (MAC).This enabled any trends to be identified and actioned.
- Patients who returned to outpatients were asked whether they have had to seek care elsewhere following their inpatient episode, for example seeking antibiotics from their GP. This identified further adverse outcomes that occurred after discharge from centre.
- As a member of the specialist orthopaedic alliance (SOA) THC shared data and best practice as benchmarking against other specialist orthopaedic hospitals. This included quality metrics which were part of the Vanguard quality kite mark standard. This also ensured THC staff participated in working groups to help to define new standards across the country.
- The centre was leading on work streams as part of the National Orthopaedic Alliance Vanguard project on behalf of NHS England as part of the new models of care initiative.
- THC told us it was the first Centre to submit data through to the Private Health Information Network (PHIN).PHIN allows independent centres to share performance data in accordance with legal requirements regulated by the Competition Markets Authority. The centre submitted their 2015 data for non-NHS funded patients to third party contractor for inclusion in PHIN before the September 2016 deadline.
- Enhanced recovery programmes (ERP)were in place for hip and knee joint replacement surgery for those patients identified as suitable. The programme is shown to have fitter patients, fewer postoperative complications ,quicker recovery from surgery and improve the overall quality of the patient experience.
- During 2016 THC was part of the Kent, Sussex and Surrey (KSS) ERP.As part of the programme providers submitted monthly data including the average length of stay for Total Hip and Knee replacements. THC was consistently at an average of 2.8 days compared to the average KSS score of 5 days for THR and TKR combined. THC had received national recognition for their work in the ERP programme and had been awarded national awards.
- Centre data showed that in December 2016 52% of knee replacement patients stood on the day of their operation and 67% of hip replacements stood on the day of surgery.

- Dislocations of total hip replacements were recorded on the THC electronic incident reporting system. This captured both dislocation at THC and dislocation post discharge. Post-discharge dislocations were identified at the 48 hour-follow up phone call, through re-admission or at the out-patient appointment where information was recorded on a post-discharge questionnaire or by direct contact with the hospital or surgeon. This meant that the information was captured if the patient has been admitted elsewhere.
- All total hip dislocations were included within the quarterly clinical governance report and the indicators were monitored for the rolling year. For the period between October 2015 and September 2016 THC reported 0.80% dislocation rate in comparison to the national average of approximately 3%.
- There were 24 cases of unplanned transfer of an inpatient to another centre between October 2015 and September 2016.The assessed rate of unplanned transfers was not high when compared to a group of independent acute centres, which submitted performance data to CQC.
- There were eight cases of unplanned readmission within 28 days of discharge in the same reporting period. The assessed rate of unplanned readmissions was not high when compared to a group of independent acute centres, which submitted performance data to CQC.
- There were three cases of unplanned return to the operating theatre in the same reporting period. These were appropriately managed and investigation undertaken to identify any learning.

Multidisciplinary working

- As part of the enhanced recovery programme (EPR), patients were asked to attend 'joint school', this combined pre-assessment, physiotherapy and occupational therapy. Patients were taught how to walk and transfer after their operation by physiotherapy and what to expect after their operation. 'Joint school' brings together a multidisciplinary team (MDT) who work together to assess and plan patients operations efficiently.
- Entries in the medical records we reviewed demonstrated a range of MDT input into patients' care. This included physiotherapy and pharmacy. Staff we spoke with reported positive multidisciplinary working relationships with colleagues.
- We observed 'team briefings' in theatres that were held prior to the start of operating lists. Surgeons, anaesthetists, and theatre staff attended the 'briefings' which allowed the team to review the operating list together and highlight any particular issues.
- The centre had many service level agreements (SLA) which provided services that were not available at the centre. For example, a local NHS trust provided critical care support, infection control and dietetics (diet and nutrition).
- The ward staff liaised with district nurses to arrange on-going care for patients post-discharge where appropriate. We saw there were contact details of who and how to contact GP's and district nurses if required.

Seven-day services (only if this is provided, if it is a day surgery service please remove this subheading)

- The centre has medical cover provided 24 hours per day, seven days per week by a resident medical officer (RMO). The RMO was on-site and attended to any patient issues or emergencies. The RMO had regular contact with the patient's admitting consultant, discussed any changes in condition or treatment or to identify the need for any further investigations.
- Anaesthetic staff were provided via a SLA, who provided an on-call service in case of emergencies. Medical cover and pharmacy services were provided 24 hours a day seven days a week by a SLA with at a local NHS trust.
- Radiology services were also provided via a SLA with an external contractor who provided an out of hours service.
- The physiotherapy team provided seven-day cover. This meant patients recovering from surgery at the weekends had the same access to physiotherapy services as recovering during the week.

Access to information

- The centre held integrated patient records on-site. As well as keeping confidential patient data safe, this ensured timely access to all the information needed for

patient care. We reviewed ten sets of notes for surgical patients. All ten contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results and care plans.

- Staff could access local policies and procedures electronically, and all staff we spoke to knew how to do this. Staff could access national guidance via the internet, and we saw computers available in staff areas to enable them to do this.
- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with their doctor and nursing staff.
- We observed a discharge from the day surgery ward and saw staff gave the patient comprehensive written and verbal information about their on-going care. This included wound care, follow-up appointments, counselling on medicines and venous thromboembolism (VTE) advice. This helped patients understand how to care for themselves and recognise any post-operative complications while they continued recovering at home.
- The centre provided discharge letters for patients and their GPs. We saw that discharge letters included all relevant information to allow continuity of care in the patient's community. This included operation details, prescribed medications and wound care. Discharge letters contained details of the treating consultant so that the patient's GP could contact them if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- THC had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- We reviewed ten consent forms for surgery. Patients and staff had fully completed, signed and dated the consents to ensure they were valid. The consent forms did not contain any abbreviations that a patient may not have understood.
- THC data showed in July 2016 100% of patients had a fully completed consent form.
- THC had a Deprivation of Liberty Standards Policy, which was in date. The policy was in line with Department of Health (DoL's Code of Practice 2009).
- We spoke to staff in theatres and on the ward who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed. However, staff told us they had never needed to apply it.
- THC had an advance decision policy, which was in date, the policy also included guidance on patients with an advance decision (AD). An advance directive is a decision a patient can make in advance to refuse specific treatment in the future.
- THC had a Mental Health Capacity Assessment form, which was completed in conjunction with the centre Mental Capacity policy. This meant there was a process for staff to follow when undertaking a mental health capacity assessment.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- We spoke with four patients who had surgery at the centre. All patients we spoke to felt staff were caring. One patient told us that the care they received was 'second to none' and another patient said 'all the safety checks undertaken made me feel at ease'.
- We saw staff took time talking to patients and explaining things to them and those people close to them. We observed encouragement and reassurance being given to post-operative patients' in recovery after surgery.
- We saw in theatres consideration was given to preserving patients' dignity, for example not opening theatre doors until patients were covered.
- The Horder Centre (THC) signed up to the national "Hello, my name is" campaign. This was a national initiative to encourage centre staff to always tell patients their name and introduce themselves. We saw that staff

always introduced themselves when they met a patient for the first time. This was in line with NICE QS15, Statement 3, 'Patient awareness of names, roles and responsibilities of healthcare professionals'.

- The most recent patient led assessment of the care environment (PLACE) score, completed in 2016 scored 96% for privacy, dignity and wellbeing at THC, which was better than the national average of 83%.
- One of THC values was caring, which was embedded throughout the organisation from recruitment of staff and as part of their performance management. This was part of 'The Horder Way', which all staff were requested to sign up to as part of their induction.
- Patients' said that staff went the extra mile and the care they received exceeded their expectations.
- Patients were cared for in single en-suite rooms, which allowed dignity and privacy to be preserved. Patients were asked prior to their admission if they were happy with their name to be on the door of their room and on the ward information board. We saw staff knocked on the patients doors before entering.
- THC participated in the NHS friends and family test for NHS-funded patients. Data between April – September 2016 showed consist scores of 99%-100%, which ranked in the top five providers each month. This meant nearly all patients would recommend the centre.
- THC received 51 items of rated feedback on the NHS Choices website between October 2015 and September 2016.One patient was likely to recommend and were 50 extremely likely to recommend the centre.

Understanding and involvement of patients and those close to them

- We saw staff took time talking to patients' and explaining things to them and those people close to them.
- There was a strong, visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity.
- Staff showed determination and creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were always reflected in how care is delivered. For example ,any individual needs of patients were documented on the whiteboard in their room, this ensured all staff were aware of them.
- THC involved patients' relatives and people close to them in their care. They told us they received full explanations of all procedures and the care they would need following their operation.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place. This also reflected patient centred care and that patients individual needs were taken into consideration.
- All patients recovering from surgery on Dufferin Ward had named nurses to care for them. This allowed patients to build positive relationships with the staff looking after them.
- The senior nurse on duty visited all ward patients daily as a minimum and sought verbal feedback for the care received. Any immediate needs or concerns were relayed to the team on duty during handover.

Emotional support

- On discharge, patients were requested to contact the ward if they have any concerns or worries. Telephone calls were made to all inpatients after discharge to check on the patient's recovery after a 24-hour period. We saw that these telephone calls were documented.
- The centre used the Butterfly scheme on its ward. This scheme supports patients with dementia and memory impairment. It aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment. Butterfly symbols were put by the patient's bed and remind staff to follow a special response plan.
- Patients' emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- There was a variety of specialist nurses and support groups available via service level agreements, for example Parkinson's UK that provided support and advice for patients.

- The centre had a group of over 70 volunteers that were available to provide support and guidance for patients. For example, volunteers could meet patients in the day room to have a chat and a drink.

Are surgery services responsive?

Outstanding ☆

We rated responsive as outstanding.

Service planning and delivery to meet the needs of local people

- The Horder Centre (THC) is (at the time of report publication) part of the Specialist Orthopaedic Alliance (SOA) leading on orthopaedic service redesign as part of the national Vanguard project for NHS England. THC had undergone a complete refurbishment and redevelopment programme over the last eight years to create a therapeutic environment to aid patient recovery ensuring the flow of services within the building matches the patient pathway.
- We saw that the new facilities were spacious and fit for purpose. Staff and patients were positive about the environment.
- THC had a mix of 96% NHS patients who had chosen THC through NHS Choices and the remainder were privately insured or self-funded.
- Between October 2015 and July 2016, there were 5,750 visits to theatre. Of these, 3,214 patients (56%) had day case surgery and 2,529 (44%) had an overnight stay.
- THC engages with all key stakeholders for example local NHS commissioners in to understand what services were required within the local community.
- THC provided patients care for their complete pathway from their first out-patient appointment at THC through to discharge after their operation.
- There was telephone and centre based pre-assessment available for patients having surgery. This meant patients who were considered low risk for an operation could have their pre-assessment done over the phone, which avoided a visit to the centre.
- All admissions for surgery were elective and planned in advance therefore service planning was straightforward as the workload was mostly predictable.
- There were weekly theatre planning meetings, this meant that theatre staff and managers met to review and discuss the operations for the forthcoming two weeks. This meant that any additional equipment could be organised and the operating lists reviewed to ensure they were achievable in the time frame. Extra staffing could be organised if there was an anticipated over run of the operating list to minimise the risk of on the day cancellations.

Access and flow

- Patients arrived at the centre either in the morning or at lunchtime depending on where they were on the operating list. Staggered arrival times meant waiting and nil by mouth time was kept to a minimum. All patients if they were a day case or staying overnight attended the day surgery ward.
- Pre- admission checks and assessments were undertaken, when completed the patient changed and waited for their operation. Staff then escorted patients to the theatre, the majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room.
- Once patients were stable and pain-free, staff took them back to the day surgery ward area or surgical ward to continue recovering. Patients who were a day case had a responsible adult to collect, escort and stay with them for 24 hours. We saw in the patients care plan there was a section that must be completed with the nominated adult's name and contact details. This ensured staff were aware who to contact when the patient was fit for discharge and who would stay with them for twenty-four hours.
- The provider reported three cancelled procedures for a non-clinical reason in the last 12 months; of these 100% were offered another appointment within 28 days of the cancelled appointment.
- During our inspection, the theatre lists ran on time. The inspection did not highlight any concerns relating to the admission, transfer, or discharge of patients form the ward or theatres.

- THC audited patient waiting times using a Patient Tracking List. This was a report that extracted information from the patient administration system into an analysed spread sheet. A designated member of staff filtered through the report to audit waiting times.
- A project team met twice weekly to discuss patient waiting times and areas of concern or focus.
- Reports on compliance with waiting times were shared with Clinical Commissioning Groups (CCGs).
- For NHS-funded patients, the centre aimed to treat 90% of patients within 18 weeks of referral as agreed with commissioners. Data for October 2015 – September 2016 showed referral to treatment (RTT) within 18 weeks was worse than the 90% national indicator in 11 months of the reporting period. The worst performing month was December 2015, when only 58% of NHS-funded patients had their operation within 18 weeks of referral. The best performing month was May 2016, when 91% of patients had their surgery within 18 weeks of referral. However, this was not the fault of THC but was a failing on referrers to submit the referrals in a timely way.

Meeting people's individual needs

- We saw that in patient rooms there was key information that related to the patient written on a notice board. For example, any risks associated with the patient, aim of the day and how the patient mobilised. This meant staff could read the information and knew the patient's specific needs.
- Patients undergoing hip and knee replacement surgery attended joint school, this was a structured, information giving session managed by an Occupational Therapist. This ensured the individual needs of patients undergoing joint replacements were discussed prior to their operation.
- There was a therapy garden within the grounds of THC, here there was a variety of surfaces for example, gravel which patients could practice walking on prior to discharge home. This meant patients could practice walking on similar surfaces to what they had at home.
- There was a patient information folder in the patients bedrooms, these contained guidance and information the patient might need during their centre admission.
- There was a day room that patients and their visitors could use instead of staying in their bedroom. This meant there was an alternative environment for patients to sit in and eat meals with their visitors if they wanted to.
- THC used a scheme where a butterfly symbol was placed by the patient's name to identify those patients living with dementia or memory- impairment. Its purpose was to improve patient safety and well-being in centre. We did not see these being used during our inspection.
- The most recent patient led assessment of the care environment (PLACE) score, undertaken in 2016, THC scored 82% for dementia care, which was better than the national average of 80%.
- In the same PLACE assessment, THC scored 82% for care provided to people with a disability, this was better than the national average of 81%.
- Nurses assessed patients' individual needs at pre-assessment clinic. Staff on Dufferin Ward told us pre-assessment staff communicated any additional needs to them in advance. This allowed staff on the ward to make appropriate arrangements before admission.
- The centre had access to face-to-face and telephone interpreters for a range of different languages. Staff we spoke with knew how to book interpreters and gave us examples of times patients had used translation services.
- We saw that all patient ensuite bathrooms on Dufferin Ward were "wet room" with level access shower facilities. We also saw additional aids to support patients with limited mobility such as shower chairs. This allowed all patients access to shower facilities.
- On Dufferin Ward, staff allocated any patients to patient rooms based on their individual needs. For example, a patient living with dementia would be allocated to a room adjacent to the nurse's station.
- Staff gave us examples of when patients had required additional support from relatives before surgery and the relatives came into the anaesthetic room with them before surgery. This allowed patients with additional needs to have their loved ones with them to provide additional comfort and support.

- Dufferin ward sometimes allocated additional health care assistants to shifts where there were patients with additional needs on the ward. This allowed staff to spend additional time with patients to ensure they felt supported and had their needs met.
- There was a Horder Healthcare Dementia Strategy 2016-2019, the strategy set out how THC worked with patients, staff and community partners to improve the care provided to those living with dementia.
- THC had named link nurses for patients living with dementia who may be called on to assist with coping strategies and the planning of care for such patients.
- There were a variety of information leaflets on display about different types of conditions and treatments. Staff told us that they were available in different languages on request. Patients felt confident that they had all the information they required and would not hesitate to ask questions if they had any queries about their care.
- We saw cards and leaflets on the wards with information for patients on how to leave feedback. In addition, the centre's website had the facility for patients to leave feedback

Learning from complaints and concerns

- THC followed the Horder Healthcare Complaints Handling Policy and Procedure, which was in date. This policy aimed to ensure that concerns and complaints were handled thoroughly without delay and with the aim of satisfying the complainant whilst being fair and open with all those involved.
- Horder Healthcare had three stages of the formal complaints process, stage one, which was handled by the clinical governance manager, stage two when a review was undertaken by the director of clinical services and stage three when an Independent external adjudication of the complaint was undertaken.
- The Chief Executive of Horder Healthcare had overall responsibility for the Complaints Policy but delegated responsibility to the director of clinical services (DoCS). The DoCS was also responsible for the review, investigation and responses to any stage two complaints. The process for receiving, acknowledging, investigating and responding to complaints at stage one lay with the Clinical Governance Manager.
- THC operations manager, matron or head of department endeavoured to handle any concerns/ complaints at a local level but if they were unable to satisfy the complainant's issue, they escalated the complaint immediately to the governance office and made a full report onto the complaints module of the electronic incident reporting system.
- The day-to-day administration of complaints was handled by the complaints lead, who ensured that all complaints/concerns received were acknowledged within two working days. The complaints lead then ensured the timely investigation of the complaint by the relevant personnel and the completion of a response letter back to the complainant within 20 working days.
- All investigation information was stored electronically on the electronic risk management system at Horder Healthcare confidentially. Only senior managers or approved personnel were given access to the system. Staff were trained in root cause analysis and ensured that all aspects of the complaint were responded to together with any learning points, changes to practice or preventative actions.
- When the governance manager and the complaints lead were satisfied that all the relevant information was available to enable a full response to be formulated and sent to the patient, the investigation would be signed off. If, during the investigation, it was identified that it would not be possible to reply to the patient within the stipulated timescale, contact was made to explain any delay with the response. The complaint response was shared with those staff involved in the investigation.
- Once the complaint had been investigated, the response letter included details of how the complainant could take the complaint to the next stage if they were not satisfied with the outcome. This could be done by contacting either the Parliamentary and Health Service Ombudsman for NHS patients or The Independent Sector Complaints Adjudication Service (ISCAS) for private patients.
- In-patients were visited by the senior nurse every day and asked for comments regarding their experience. Any issues were aimed to be resolved swiftly at a local level. Patients were encouraged to complete the patient

feedback questionnaire on discharge. The questionnaires were reviewed by THC operations manager who telephoned the patient to discuss their concerns and take any appropriate action.

- We saw 'listening to you' leaflets- a guide to making comments and complaints' booklet in patients rooms and around THC, these detailed how patients and visitors could give feedback or make a formal complaint.
- Complaints were discussed at monthly heads of department meetings and these staff were responsible for cascading information down to their staff.
- Complaint reports were also produced by the governance team for dissemination of shared learning to departments. Complaints were reviewed at the quarterly clinical governance meeting (CGM) which included the director of clinical services (DoCS), senior clinical managers, medical director and chairman of the medical advisory committee (MAC).
- The board were informed of complaints monthly via key performance indicators and were also reviewed in depth by a member of the board clinical governance committee (CGC) every six months. The chairman of the board CGC reported formally to the board. The DoCS ensured any significant complaints were added to the corporate risk register.
- The CQC received one complaint regarding THC between October 2015 and September 2016. The provider did not supply complaints data specifically relating to surgery. THC received 24 complaints in the same time period. None of these complaints had been referred to the Ombudsman or ISCAS.
- THC audited compliance meeting the acknowledgment of a complaint within two working days and the full response within 20 working days and this showed 100% compliance.
- Staff were able to give us examples of complaints that had been made and changes made as a result of complaints. For example, the anaesthetist now documented the discussion with the patient regarding the type of anaesthetic that would be given and the use of urinary catheters during surgery was now discussed with patients during pre-assessment.

Are surgery services well-led?

Good

We rated well-led as good

Leadership / culture of service related to this core service

- We saw strong leadership, commitment and support from the senior team at department level within the service. The senior staff were often responsive, accessible and available to support staff during challenging situations.
- Managers we spoke with appeared knowledgeable about their patient's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities.
- Ward staff told us that senior nursing staff, consultants and doctors could be seen on the wards and they were approachable and helpful.
- Staff told us they thought managers were very supportive and that there was clear leadership from managers and the matron. We observed the theatres were well managed with good leadership.
- Staff told us one of the best things about working at the centre was the team. Staff descriptions of the culture included "we are like a family" and "everyone is lovely". We observed positive working relationships between staff. Due to the small size of THC, everyone knew each other's names and we observed friendly interactions between staff from all departments in the centre.
- Staff we met were all welcoming, friendly, and helpful, morale was good, and staff told us they felt 'proud' to work at THC.
- There was a strong culture of openness and transparency. For example, we saw that the vast majority of incidents the centre reported were "no harm" which indicated a good reporting culture. The service actively encouraged staff to raise concerns.
- Staff were committed to making improvements for patients and felt they had been given the right tools to achieve this.

Outstanding ☆

Surgery

Vision and strategy for this this core service

- Horder Healthcare's (HH) charitable purpose was to advance health and the relief of patients suffering from ill health. The mission was to be a leading provider of high quality healthcare services, demonstrably improving patient's health.
- The strategic aims of HH were:
- Maintain a robust business that is capable of generating a reasonable surplus in order to invest in the achievement of our charitable purpose and strategic aims.
- To create a therapeutic environment in order to help people achieve their optimum and well-being.
- Develop their people and embed continuous improvement.
- Enlighten practice and people through the development and giving of knowledge: capitalise on the smart use of technology.
- Lead continuous and meaningful engagement of key stakeholders.
- Extend HH's unique brand of care in order to provide benefit to ever increasing number of people.
- The vision and values for HH were agreed by the board and were visible throughout the THC, they were displayed on staff notice boards and within individual departments.
- The business strategy was communicated by the executive team through staff communication processes, information boards, dissemination of information in team meetings and business forums. Heads of Departments linked business objectives to departmental and then personal objectives through the appraisal process.
- THC operations manager and matron used a variety of strategies to communicate the vision such as staff forums, weekly operations communications and open communication forums.
- Staff were able to describe to us the vision and values of the 'Horder Way.' This included five core values of caring, friendly, quality, integrity and pride. We were told this also formed part of the interview process, appraisal and that new staff have to demonstrate the values during interview workshops.
- A 'Horder Way' strategy was launched this year which engaged the following five elements:
- Patient Experience
- Research & Education
- Staff engagement
- Accountability and Performance
- Training & Development

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The board of directors had overarching governance responsibility, this fed into the board governance committee, clinical governance committee and medical advisory committee. These committees then fed into six other committees, teams or departments for example, head of departments, infection control committee and clinical forum committee. This structure ensured the two way sharing of information and dissemination.
- THC operations manager had overall management responsibility, they were supported by a matron, who was supported by a theatre manager, day surgery manager and ward manager.
- Horder Healthcare had a Risk Management Policy, which was in date and referenced national guidance for example, Risk Assessment Framework (Monitor 2014). The policy clearly defined staff roles and expectations with regard to reporting and responding to risk. This included a monthly review of risk registers and a quarterly review of the corporate risk register. The Chief Executive had overall accountability for risk management.
- At Horder Healthcare (HH), the overall responsibility for clinical governance (CG) and risk management was delegated to the director of clinical services (DoCS) who reported directly to the Chief Executive and to the board of directors via the clinical governance committee and the audit committee. The DoCS attended the centre quarterly clinical governance committee (CGC) meeting,

led by the chairman of the medical advisory committee (MAC) and the medical director. The committee included the clinical governance manager and operational leads from the multi-disciplinary teams.

- MAC meetings were undertaken quarterly and as part of a consultant practicing privileges, they were required to attend at least two meetings a year. We saw MAC meeting minutes, which confirmed they were well attended by a variety of specialities.
- MAC meeting minutes showed the meetings were used to discuss improvements to patient care and ensure care is evidence based. For example, we saw in the April 2016 post surgery physiotherapy was discussed to ensure the best outcomes were achieved for patients.
- The clinical governance committee met quarterly and discussed incidents, complaints, infection control issues and risk register review. There was also a standing agenda item to review National Institute for Health and Care Excellence (NICE) guidelines, to ensure the centre implemented and maintained best practice. We reviewed the minutes of clinical governance committee meetings held in May and July 2015 and January and April 2016, which confirmed this.
- We saw minutes of the various meetings for example theatres and ward meetings. We saw trends in incidents and complaints were identified, in addition, serious incidents, safeguarding, patient feedback and complaints were discussed.
- A Risk Scrutiny Group (RSG) provided assurance and identified high-level risks on the board assurance framework, corporate risk register and any risks escalated by departments. The RSG was chaired by the director of clinical services. Surgical services could escalate risks to be reviewed by the RSG, which met quarterly.
- There was an effective system for identifying and reporting risk through the 'Horder Health Safety teams'. The safety teams were responsible for ensuring risks were identified and placed onto the electronic reporting system. The teams were also responsible for ensuring investigations took place and learning was shared. This included feedback from audits, incidents, serious incidents requiring investigation and never events. They were also responsible for communicating any recommendations from the National Reporting and Learning System (NRLS), Health & Safety Executive (HSE), MHRA and other Alert Notices to all staff across the centre.
- Staff said they generally received information regarding incidents and were involved in making changes as a result of incident investigations.
- Surgical services had completed local as well as national audits. For example, a regular audit had been completed to ensure that compliance with the consent process and an audit was undertaken on the quality of patient records.
- THC had a risk register which included nine risks, the register was centre wide and not surgical specific however it did contain risks that were relevant to surgery. For example, the register highlighted that the central sterile supply department (CSSD) water plant was at the end of its life and if it failed, it would affect the supply of sterile surgical instruments. During our inspection, we saw evidence, which confirmed the water plant was going to be replaced within weeks of our inspection.
- We reviewed THC risk register and noted that all nine highlighted risks had been reviewed within the last 12 months. We saw that all risks had controls in place to mitigate the risks. For example, the risk of failure to achieve compliance within the 18-week expectations was mitigated by twice-weekly meetings regarding 18-week issues.
- The risk register was discussed at each departmental clinical governance meetings and we saw evidence of this in meeting minutes.
- THC had a performance dashboard, which monitored monthly performance in a range of key areas relating to surgery. These included monthly WHO five steps to safer surgery audits, NEWS chart completion, and early mobilisation.
- We saw that staff received feedback on key performance indicators at department meetings and they were displayed on Dufferin ward. This meant the service addressed any deterioration in performance and highlighted positive practice.

Public and staff engagement (local and service level if this is the main core service)

Outstanding ☆

Surgery

- The centre actively engaged with staff through open staff forums and an annual staff survey.
- There was a strong emphasis on promoting the safety and wellbeing of staff, this included a system that encouraged staff to take breaks away from computer screens. After a set period of time, staff were reminded to take a break and offered the option of following desk exercises on screen. Staff feedback regarding this tool was positive, as it was a reminded them it was ok to take a break and that managers were considering their wellbeing.
- THC demonstrated commitment to its value of wellbeing. Initiatives to support staff wellbeing included providing free meals cooked on site, use of the gym and free parking. Staff were extremely positive about these initiatives.
- Staff had access to a clinical skills room, which gave them the opportunity to practice and learn new skills with the support of an education facilitator. Staff spoke positively about this facility as it gave them protected time to develop and learn skills.
- The centre offered a range of internal and external training opportunities to help staff continually learn.
- THC had over 75 volunteers who provided additional support to staff and patients .We spoke to a volunteer who was responsible for stocking up on Dufferin ward, they were extremely positive about volunteering at THC. Staff told us that a high proportion of the volunteers were former patients of THC who had had such a positive experience when they were a patient.
- Sickness rates for nurses, operating department practitioners and health care assistants in theatres were higher than the average of other independent acute centres we hold this type of data for eight months of the reporting period (October 2015 to September 2016).
- Sickness rates for inpatient nurses were variable in the same reporting period. The rates were higher than the average of other independent acute centres we hold this type of data for. The highest rate was in February 2016 (10%) and the lowest was in July, August and September 2016 (0%).
- Sickness rates for health care assistants in inpatient departments were 0% or lower than the average of other independent acute centres, we hold this type of data for 10 months of the reporting period.
- Patients were encouraged to leave feedback about their experience in outpatients by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data for all patients between July and December 2015 showed the centre had consistently high scores (greater than 98%) and the response rates varied between 25% and 64%. The response rates for this period were the same as, or better than the average response rates for NHS patients in England. This showed that most patients were positive about recommending the department to their friends and family.
- A minimum of two patient forums were held each year with very positive feedback. During 2015, patients participated in discussions regarding communications and quality improvements. In February 2016, there was a patient forum, which discussed the patient dining experience. The forum gave patients and their relatives the opportunity to give feedback and make suggestions for improvement in a face-to-face environment.
- HH website included information for patients on healthy living and eating, news and health information.
- HH sent out an e-newsletter to subscribers monthly which included healthy living information, recipes, latest news and details of all the latest events happening across HH sites.
- In addition, there was a quarterly 'Making Strides' magazine consisting of a range of healthy living tips, advice, health information and various articles from experts.
- The centre engaged with the local community through a range of projects.
- THC consultants and physiotherapists regularly engaged with GPs, practice staff and members of the public providing valuable education sessions. Recent topics have included looking after your hips and knees, managing arthritis and joint replacement surgery and the recovery process.

- Consultants and physiotherapists also attended GP practices to deliver tailored education sessions for all practice staff.
- HH interacts on social media via Facebook, Twitter and LinkedIn.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- THC had successfully been accredited with venous thromboembolism (VTE) exemplar status. Organisations are awarded VTE Exemplar Centre status if they are able to demonstrate that they are delivering best practice as defined by the NICE Quality Standard for VTE prevention (QS3) and are taking an active role in their own local area in relation to disseminating best practice .For example, hosting VTE study days, educational events, contributing to publications and undertaking research).
- THC planned to develop the use of a electronic application for at least five different procedures across HH with access for patients to specific information for their operation and health/well-being information and videos.
- There was an active recruitment process in place to fill vacancies and to increase employed numbers of staff throughout THC. This would decrease the level of agency nurses currently required to ensure a safe service. During the recruitment process THC were looking to ensure, new members of THC team were able to work across the two HH sites to give additional flexibility.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good;

Incidents

- There were no Never Events in the reporting period from October 2015 to September 2016. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There were 20 clinical incidents within the outpatient and diagnostic imaging services between October 2015 to September 2016, this accounted for 5% of all reported incidents, this was not high when compared to other independent hospitals we collect data for.
- The rate of clinical incidents, per 100 outpatient attendances, was variable throughout the reporting period with the highest rate of 11 incidents occurring between January and March 2016.
- Six non-clinical incidents were reported within the department from October 2015 to September 2016. This was not high when compared to other independent hospitals we collect data for.
- The hospital followed their corporate "Incident Reporting and Risk Management Database Policy & Procedure" (dated September 2015). The Director of Clinical Services was accountable for ensuring that policies and procedures were in place for effective reporting, recording and investigation of all reported incidents, complaints and safety alerts.
- All clinical and non-clinical staff, irrespective of grade or place of work could access and enter information regarding incidents, complaints and safety alerts.
- There was a nominated member of staff in outpatients and diagnostics who acted as a 'Super User'. Their role included reporting to their department any issues around incident reporting as well as ensuring new staff were trained on how to use and access the electronic reporting system. The super users also fed back to the department about issues that were raised at the 'Datix' user group meeting which were held once a quarter. This system ensured clear responsibilities with incident reporting.
- We saw minutes of the clinical governance committee and heads of department meetings which showed staff and managers discussed incidents and outcomes every month.
- The outpatient manager and staff told us feedback and learning from incidents occurred during the monthly team meetings and weekly 'hub' meetings. We looked at 'hub' and team meeting minutes and saw feedback from incidents had taken place.
- A service level agreement (SLA) was in place with Medical Imaging Partnership who fed back any incidents to the Horder Centre through monthly department meetings, or as and when needed. We were given a recent example of an incident that occurred in the imaging department and staff demonstrated a cohesive process to ensure learning was fedback to all staff.

- Staff described the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It 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 within the department were told when they were affected by an event where something unexpected or unintended had happened. We saw examples where the hospital had followed the duty of candour and complaint response process. We also saw the duty of candour discussed in MAC meetings as a regular action.

Cleanliness, infection control and hygiene

- There was a dedicated infection control link nurse for the department. Link nurses are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their department and to motivate staff to improve practice. The link nurse for the outpatient department had recently taken up the role, and was undergoing further training.
- We found equipment was clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection prevention and control.
- We saw personal protective equipment, hand washing basins and hand sanitising gel was available in consultation and treatment rooms. Hand gel was available in communal areas although it was not prominently displayed. During our inspection we did not observe any patients using the dispensers.
- Posters were positioned near hand washing basins which explained "5 moments for hand hygiene" in line with World Health Organisation guidance.
- The minutes of the IPC meetings were kept on file by the IPCC and were available for all staff to read. We saw infection rates were discussed at 'hub' meetings, ward meetings and heads of departments meetings.
- Water was tested on a regular basis and results and certificates were held with the estates Department. We reviewed actions and testing results and saw appropriate actions were taken and that records were complete.
- We saw that out of hours and at weekends Human Resources (HR) kept a record of communicable diseases for staff to access. Any occurrences were reported to the senior nurse on Dufferin ward and HR would record the incident. Catering and Housekeeping would also liaise with the senior nurse during these periods. We saw a system was in place to deep clean areas following an infectious patient having been in the department.
- The IPCC met with the MAC quarterly and reported on any issues regarding infection prevention and control. We reviewed minutes of the MAC meetings and saw mixed levels of input from the IPCC, due in part to the recent employment of a new IPCC lead.
- Staff were able to describe what actions they would take if they suspected an infection. This included contacting the IPCC.
- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant that the couches could easily be cleaned between patients.
- Chairs in the outpatients waiting areas had fabric backs which was not in line with HBN 3.133 'Soft furnishings' for example, seating used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam-free or heat-sealed.' However, the hospital had minimised the risk by choosing material that was resistant to bacteria, was anti-fungal and MRSA resistant they had also purchased a specialist steam cleaner and followed a schedule for cleaning the chairs. We saw protocols to follow if a spillage occurred. All these measures helped to minimise the spread of germs.
- Flooring throughout the department was mostly compliant and followed guidelines for effective cleaning in line with HBN 3.110 'There should be coving between the floor and the wall to prevent accumulation of dust and dirt in corners and crevices.' However, we did see

some areas with no covered edging in the consultation rooms in pre-assessment. We also saw some areas of the physiotherapy gym where flooring was not covered and there was sealant coming away from the skirting.

- The hospitals Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed the hospital scored the same as the England national average for cleanliness scoring with 98%. They scored above the national average of 93% for condition, appearance and maintenance with a score of 94%.
- In all the consulting and treatment rooms we visited, disposable curtains were used. They were all labelled with the date on which they were put up, which in all cases was within the last month. Staff were aware they needed to be changed every six months or sooner if they became visibly dirty.
- Outpatients had an ongoing audit schedule. This included environmental audits, hand hygiene, Isolation precaution and management of patient equipment, general and specialist area.
- Hand hygiene audits carried out from March 2016 to November 2016 showed that the outpatient department were consistently falling below hospital targets with only 50% of staff being fully compliant this fell to 20% in July 2016. The audit showed poor compliance with staff keeping nails short and not wearing rings. This was highlighted in an IPC meeting held in October by the newly appointed lead for infection control and during inspection all staff we saw were seen to have short nails and no jewellery, showing that improvements were being made.

Environment and equipment

- We saw three resuscitation trolleys in outpatient and diagnostic imaging areas. The trolleys were secured with tags, which were removed on days when clinics operated to check the trolley and contents were in date. All drawers had correct consumables and medicines in accordance with the check list. We saw consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order.
- Throughout the department we saw several pieces of electrical equipment, all had stickers which indicated it had been serviced regularly and when the next service was due. This gave staff assurances that the equipment they were using was safe.
- Medical Imaging Partnership (MIP) had sole responsibility for ensuring the equipment in diagnostic imaging was serviced regularly and service records were completed and in date. Horder Centre held a service level agreement with MIP which we reviewed.
- The hospital staff told us all equipment was tested as per policy timeframes and the evidence of testing and when next due is held centrally in folders and online, we saw this on inspection.
- The department had two changing cubicles available for patients to prepare for an examination with lockable doors. We saw lockers available for patients to use to store their belongings in whilst they had an examination.
- In all examination rooms visited we saw consumables stored were in date.
- There was disabled access throughout the department. We saw disabled toilets in the main entrance as well as in the outpatients department which were compliant with the Health Building Note (HBN) requirements.
- Emergency call bells were available in all clinical areas and consulting rooms in the outpatient department to alert staff to a medical emergency.
- Staff signed a label on the sharps bins which indicated the date it had been constructed and by who. This was in line with health and safety regulation 5 (1) d, which requires staff to place secure containers and instruction for safe disposal of medical sharps close to the work area. All sharps bins we saw were below the fill line in line with recommendations.
- Waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations.

- Fire escapes were clearly signposted and fire doors in place to protect patients and staff in the event of a fire. We saw a clear procedure and policy to follow in the event of a fire.
- We saw a risk to staff and patients of slips and trips due to deterioration of walking surfaces throughout the exterior MRI walk way. We were told by staff the estates team were, at the time of the inspection, engaging contractors to undertake improvements to the walkway before the weather deteriorated. In the meantime wet floor signs were being displayed in wet conditions to ensure patient safety. We saw this was also on the hospital risk register showing that it had been identified and actions were being taken to remedy the problem.

Medicines

- The hospital had safe systems and processes in place for the management of medicines in the outpatient department. We saw medicines were kept in a secure cupboard and the keys for those cupboards were kept in a secured room.
- We reviewed the hospitals prescription pad records and these were recorded correctly. All prescription pads were kept in a locked cupboard. We saw evidence of the prescribing pad log which was up to date, showing serial number, date and time when the prescription pads were last used.
- Patient Group Directives (PGDs) provide a legal framework that allows the supply and/or administration of a specific medicine by name, authorised, registered professional. We saw PGDs from medicines administered in diagnostic imaging was the responsibility of Medical Imaging Partnership (MIP). PGDs were not required in the outpatients department.
- We saw that, when applicable, medicines were stored in dedicated medicines fridges. Records showed that daily checks were undertaken. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range.
- Patient information on medication was written clearly. Patients we spoke with told us they understood what medication they needed and when to take it after discharge. We also witnessed a patient being told when and why they should stop taking medication prior to surgery, and being given written information confirming this.

For our detailed findings on medicines please see the Safe section in the Surgery report.

Records

- The hospital reported no instances where medical records were not available between August to September 2016. However, there was a procedure in place if this was to happen. We were told temporary notes were created if patient's notes were not available. The temporary notes would be made up of all relevant patient information including previous episode documentation for the outpatient appointment.
- The provider told us if 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 management 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.
- At the time of inspection we saw patients personal information and medical records were managed safely and securely. During clinics, all medical records were kept in a locked trolley and transferred to the consultant when the patient arrived. Staff told us that they had no difficulty in retrieving medical records for clinic appointments.
- Clinic letters were stored electronically, The Horder Centre maintained a full, contemporaneous hard copy of each patient's medical record which was stored on site for two years and then archived off site with easy retrieval processes.This meant an up to date medical record was accessible to all authorised staff via the computer system.

- Notes were stored in an off site storage facility and held for two years post discharge. These notes could be retrieved within 12 hours for urgent requests and 72 hours for non-urgent requests.
- Medical records were taken off site for outreach clinics. They were transferred in a sealed bag by a porter employed by the organisation. The clinician's initials and date of clinic were on the front of the bag. A signature sheet was completed at collection by a porter and a further signature sheet was completed by the recipient at the Outreach clinic. Following the outpatient clinic; the notes were placed in a sealed bag back to the main site and given to either the Medical secretaries or pre assessment to carry out further action.
- 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.
- We saw the medical records of five patients. All medical records were tidy with no loose filing, legible, dated and signed, which was in accordance with the hospital's documentation policy.

Safeguarding

- There had been no safeguarding concerns reported to CQC in the reporting period from October 2015 to September 2016.
- The matron was the location lead and first point of contact for any safeguarding concerns raised on a day to day basis. Concerns were then escalated further to the director of clinical services and on to the relevant external adult protection team.
- The matron had completed child and adult safeguarding training at level 3. All other staff had completed level 2 safeguarding in line with national guidance.
- All members of staff we spoke with had a clear understanding of safeguarding and their responsibilities to report any safeguarding issues. We were given an example where this had happened and saw all relevant steps had been undertaken in line with the hospital policy.

Mandatory training

- In-house mandatory training was organised on a regular basis. Throughout the year 2015 to 2016, six sessions for both clinical and non-clinical staff were held. Attendance was monitored and recorded. All staff also complete annual mandatory e-learning.
- The physiotherapy department held weekly additional training sessions. These were either led by staff or by outside speakers on a given subject. Staff we spoke to said they were incredibly useful and helped to bring the team together as well as aiding career development.
- Mandatory training was monitored and a computerised record held for each department as to staff progress. In the outpatients department 100% of staff were up to date with mandatory training.
- Human Resources were responsible for developing and maintaining the e-learning platform and advertising the courses in the weekly operational bulletin. They also had oversight of completion records so could inform managers of individuals who were falling behind expectations, or operational managers if a whole department was.

Nursing staffing

- There are no set guidelines on safe staffing levels for outpatient departments. Outpatient department staffing levels and skill mix were planned and reviewed on a daily basis to ensure the correct number of staff required to be on duty to ensure safe care and treatment of patients at all times.
- In outpatients and diagnostics there was a planned ratio of 1.1 nurses to one health care assistant (HCA). We reviewed the rotas and found this was met on most occasions.
- Staff told us care and treatment is only cancelled or delayed when absolutely necessary. We were given a recent example where a clinic was nearly cancelled as

there was not adequate staff available, however, the department manager was able to speak to other staff in the hospital and cover the shortfall and avoid the cancellation of the clinic.

- There were 6.6 full time equivalent (FTE) HCA and 7.6 nursing and midwifery registered staff members employed within the department.
- From October 2015 to June 2016 (with the exception of April 2016) the use of bank and agency nurses and HCAs within the department was higher than the average of other independent acute hospitals we hold this type of data for the reporting period from October 2015 to June 2016.
- The hospital had recognised this as a potential risk and had recently had a recruitment drive to reduce the amount of bank and agency staff being used. There were no agency nurses working in outpatient departments from July 2016 to September 2016, showing this initiative was starting to have a positive impact.
- We were told the department used regular bank and agency staff wherever possible ensuring staff were familiar with the department to maintain consistency.
- We saw an induction pack for new starters in outpatients which was comprehensive and staff we spoke with felt they were well supported when they started.
- A physiotherapist we spoke with had started within the last three months. She described an induction booklet which included a section where new staff had to visit each department within the hospital. Within the departments they were instructed to speak to staff to get answers to a set of questions that related to their service. This enabled the new staff to understand each department and interact with staff members from across the hospital.

Medical staffing

- Consultants are assigned an HCA or nurse for each clinic. There were also separate clinics run by a nurse alongside these for patients requiring venepuncture.
- The hospital has a RMO onsite 24 hours a day, seven days a week to support the clinical team in the event of an emergency or with patients requiring additional medical support.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics if needed.
- An anaesthetist was available on Tuesdays and Thursdays to help with the pre-assessment of more complicated patients.

Emergency awareness and training

- There was a major incident team (MIT) who co-ordinate all major incident planning. This included the centre operations manager, facilities manager, IT network manager, matron and theatre manager among others.
- THC ' included flow charts of actions to be taken in of the event of a major incident, including, loss of mains power, gas and water supply, explosion, release of toxic gases, flooding and/or severe storm damage, loss of essential facilities, failure of the medical gas system, pandemic outbreak and fire'. The strategic development manager facilitated an overall review every six-months.
- A generator would provide supplies to all of the Horder Centre in the event of power loss.
- The Horder Centre is a member of the local NHS Hospitals Trust Emergency Planning Group. There was an agreement in place with this group which provided support to the hospital from local NHS organisations in the event of a major incident.
- We saw that the Horder Centre risk register had highlighted out of date on-call process and procedures in the event of an emergency as a potential risk. As a result they had reviewed and changed the on-call process and procedures and made improvements to direct clinical and management responses. Including the increase in availability of key senior staff members to ensure an improvement to the balance and safety of responses during an incident.
- Staff we spoke with were able to describe their role in emergency situations and could explain where to find the policy if needed.
- Staff in outpatients described two recent emergency scenarios, one involving a patient collapse in the car park and another within the hospital itself. They

described a clear protocol and effective team working to ensure patient safety and dignity was upheld at all times. This showed the emergency awareness and training was embedded within the department.

- We were informed that following on from any major incident, all staff involved were given a de-brief and offered support.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate the service for effectiveness.

We found:

Evidence-based care and treatment

- The department undertook a variety of local audits. They were to check equipment, medicines management, electronic records, hand hygiene and monthly spot check audits. We saw examples of these audits, along with action plans arising from them.
- We identified these audits were not always robust and the action plans from them were not focused and specific. These included hand hygiene, environmental, cannula and catheter audits. We spoke to the Infection Prevention and Control (IPC) nurse who had also identified this as an issue and they already had a plan to improve the effectiveness of audit as a result.
- The imaging service conformed to regulations under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and in accordance with the Royal College of Radiographers standards. However, this was managed by MIP and only reported to Horder Centre in the joint service review. The joint service review gave assurance that the MIP were complying with all associated and recommended professional bodies.
- The director of clinical services received guidance from outside organisations, such as The National Institute for Health and Care Excellence (NICE). We were told when such information is relevant to the Horder Centre it is presented to the weekly heads of department meeting and/or risk management committee.
- We reviewed a recent 'Prescribing and Medicines Reconciliation' audit. It showed good compliance in most areas, when scoring fell below expectations there was a comments section for explanation and an actions section to allow for changes in practice and recommendations.
- Staff in outpatients, pre assessment and physiotherapy had a good awareness of, and had read local policies. They were able to give us examples of how to find policies and when they had used them.

Pain relief

- During our inspection patients we spoke with had not required pain relief during their appointments. They told us that pain was discussed with their consultants during their appointments.
- We witnessed a patient being informed, in pre assessment, of the pain they may experience post operatively and also ways to reduce this.
- Pain assessments and effectiveness of intervention is reviewed as part of the clinical audit schedule.

Nutrition and hydration

- We were told patients would be offered tea or coffee if clinics were running late, however this rarely happened.
- Water was available in waiting areas for patients and their relatives.
- The hospital café offered a range of hot and cold food and drinks that could be purchased for patients and visitors.

Patient outcomes

- The Horder Centre participated in many national data programmes including the National Joint Registry (NJR) and the National Patient Reported Outcome Measures programme (PROMS). The PROMs questionnaires ask patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This data was reviewed to ensure the hospital only offers prosthesis that gave the best long term results for patients.
- The PROMS data for primary knee replacement showed the hospital's adjusted average health gain is

significantly better than the England average for the following measures: EQ-5D Index (Generic health status measure) Out of 701 modelled records 83.6% were reported as improved and 5.8% as worsened.

- The Oxford Knee Score reported out of 746 modelled records 93.6% were reported as improved and 5.5% as worsened.
- The hospital's adjusted average health gain for PROMs, primary hip replacement is also better than the England average with 91.2% reported as improved and 3.9% as worsened from 645 modelled records.
- Oxford Hip Score reported out of the 680 modelled records 97.6% were reported as improved and 1.9% as worsened.
- The hospital told us it was the first hospital to submit data through to the Private Health Information Network (PHIN). PHIN is an independent, not-for-profit organisation that publishes trustworthy, comprehensive data to help patients make informed decisions regarding their treatment options, and to help providers improve standards.
- We were told returning patients are asked whether they have had to seek care elsewhere following their inpatient episode, for example seeking antibiotics from their GP or having been readmitted to another provider to try to identify and further adverse outcomes that occurred post discharge.
- NEWS Quarterly Audit from July 2016 to September 2016 showed 100% compliance. This showed patient deterioration was being well managed, audited to check compliance and adhered to by staff.
- The department employed an occupational therapist (OT) who ran a 'Joint school.' These sessions were attended by patients and their relatives to help them pre and post-surgery. We saw patients enjoying these sessions and the OT said they were well attended.
- Physiotherapy was booked in for patients following surgery by booking clerks within the hospital. The clerical department handled all booking from initial consultation through to follow up and post-operative care. This meant patients received joined up care from start to finish from the Horder Centre.
- We saw evidence of a clear process in place for patients who had become critically unwell in the outpatients department and required admission to hospital. The hospital followed the hospitals "Adult Resuscitation Policy" (revised February 2016).
- A consultant we spoke with gave us an example of a recent incident where a patient had become unwell in the department, and had to be transferred to the local NHS hospital. They described how well the transfer had been implemented and that the staff responded quickly.
- We saw three emergency trolleys within the department, one in outpatients, one in pre assessment and one within diagnostic and imaging. This meant that in the event of an emergency or patient collapse, staff would be able to obtain emergency equipment without delay.

Competent staff

- At the time of inspection 100% of outpatient nurses and health care assistants had their appraisals completed in the current appraisal year.
- The hospital conducted annual checks to make sure all the nurses were registered with the Nursing and Midwifery Council (NMC) and is considered good practice. At the time of inspection 100% of nurses who worked in the outpatient department for 12 months or more had validation of professional registration.
- The hospital monitored consultants working under practising privileges. There were systems in place to ensure that consultants were competent to perform their roles, and records were kept and monitored to ensure that both consultants and the RMO had DBS checks, appraisals, and relevant qualifications in place to perform their roles.
- The hospital gained assurances through monthly meetings with Medical Imaging Partnership that staff were up to date with all mandatory training and appraisals.
- Learning needs were identified formally through appraisals. All staff we spoke to throughout our inspection talked about training being widely encouraged and staff had no issues accessing further training. Staff said they felt encouraged and were given opportunities to develop.

Good

Outpatients and diagnostic imaging

- There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection.
- The HR department ran internal workshops for staff to further their development and support them in their roles. Recent examples were handling difficult situations and getting the most out of appraisals.

Multidisciplinary working

- 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.
- Teams within the hospital worked in a co-ordinated way. We saw and heard of examples where patients had been moved between teams. The hospital took a holistic approach to patient care from admission to discharge including occupational health and physiotherapy.
- Pre assessment clinics allowed ample time and were in-depth. We were told clinics often required staff from all areas of the hospital to assess a patient's suitability for surgery. This included involvement from the anaesthetists, consultants, and consultation with the GP surgery.
- We witnessed this in a pre-assessment where a patient's medical history required further clarification. The pre-assessment nurse explained to the patient they would have to contact their GP for further explanation of the patient's history, and to further assess the patient was suitable for surgery.

Access to information

- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system. This was a 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 this system as well as the outreach clinics. A consultant we spoke with said he thought the system was efficient and had no issues with accessing information.
- We saw robust mechanisms in place for when people moved between teams and services, including at referral, discharge, transfer and transition. All patient pathways are managed centrally within the hospital and patient information was passed between teams effectively within the clerical department.
- 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 alongside weekly hub meetings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a Deprivation of Liberty Standards Policy dated April 2015. If it was assessed that the care or treatment of a patient required a deprivation of liberty then a referral and transfer was arranged to an appropriate facility. The policy was available on the shared drive. We reviewed a Mental Health Capacity Assessment and found it to be thorough and clear.
- The hospital had an Advance Directive Policy (AD) dated June 2016. The directives has been replaced by 'decisions' following the introduction of the Mental Capacity Act of 2005. An advance decision allows family, carers and health professionals know whether a person wants to refuse specific treatments in the future. This means they will know a persons wishes if they are unable to make or communicate those decisions.
- Hospital policy stated that patients who disclosed an AD within the outpatient setting would have this noted in their medical record. If the patient has at that time completed a consent form for future surgery, the presence of the AD can be confirmed by a tick in the appropriate box on the consent form. During a medical records audit carried out by the hospital it showed that in all months that an AD had been identified that the consent form had not been filled out correctly all of the time. This indicated that the policy had not been implemented properly throughout the hospital and that they were not using the recommended title for these decisions in line with the Mental Capacity Act.

Are outpatients and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging

Outstanding ☆

We rated caring as outstanding;

Compassionate care

- We saw staff take the time to interact with people who use the service and those close to them. All staff introduced themselves in line with NICE QS15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
- We saw posters informing patients that chaperones were available on display in the waiting areas and in all the consulting and treatment rooms. Patients were given the opportunity to accept or decline a chaperone during their appointment with a consultant. The decision to accept or decline was recorded in the chaperoning register.
- Staff followed the hospital chaperone policy, where possible, the same gender as the service user. Where this is not possible the patient is informed and re-booked if needed. Staff we spoke to could not recall a time where this had happened as chaperones were readily available.
- Patient's privacy and dignity was maintained throughout the department. We saw curtains drawn when appropriate and consultation rooms had signs on stating they were occupied.
- The reception desk was set away from the main outpatients waiting area meaning service users could speak to the receptionist without being overheard.
- Place scores for privacy, dignity and wellbeing were above the national average of 83% with a score of 96% being reported from February 2016 to June 2016.
- Patients we spoke with were overwhelmingly positive about the care received. With comments like "Excellent, kind, professional. It's like coming to a hotel" and "Everything is top notch, I can't complain about anything."
- Friends and family results were not broken down into departments, however overall the hospital score between April 2016 and September 2016 was on average 92%. The average response rate for the same period was 40%. Both of these were above the national average.
- We received 8 responses from CQC feedback cards that were placed in the outpatients department before our inspection. They were overwhelmingly positive. One comment received read, "Staff approached me with both dignity and respect at all times." Another read, "There is a lovely atmosphere."

Understanding and involvement of patients and those close to them

- We saw staff members talking to patients about the care the treatment they would be receiving in a clear and caring manner. Staff members checked the patient was clear about the treatment they would be receiving and asked if they had any further questions.
- Patients we spoke with felt they were fully informed and felt staff communicated well. One patient described staff as, "Wonderful, very nice and professional."
- We saw patients being given the time to ask questions after appointments in line with NICE QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.
- Patients are given any follow up appointment information and informed of when and how to access any test results before leaving the hospital. We saw patient information being handed to patients which included specific information relating to their treatment.
- We were told the hospital offers additional support to patients who may require it. This included allowing carers to attend clinics with patients and providing language interpreters.
- Patients are discharged with a contact number for the hospital and an emergency number out of hours for and queries or further questions they may have following treatment or consultation.
- We observed consultants behaving in a friendly and respectful manner towards the patients in their care. Most of the consultants came out to the waiting area to greet and show patients to their consulting room.

Good

Outpatients and diagnostic imaging

- Patients in physiotherapy were offered joint sessions post-surgery, this offered them the opportunity to meet people who were having similar treatment. A patient we spoke with spoke positively about this service saying, "It's a great help to make friends and get extra support from someone who knows what you have been through."

Emotional support

- Staff we spoke with showed compassion and understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them. We saw a staff member discussing counselling options for a patient who she felt would benefit from this.
- All treatment and consultation rooms were private and could be used to deliver any bad news which may adversely affect a patient's future. Staff told us the consultants would inform them if they were about to break bad news to a patient so they would be available to support them. They spent as much time as was needed with the patient and those close to them. They provided support and gave them guidance on where to get further help and support.
- We heard an example where staff went above and beyond to enable a patient with a mental illness to access the service, this was achieved by offering emotional support and allowing their pet to attend clinic with them.
- The hospital had over 70 volunteers doing a variety of jobs throughout the hospital; many of them were former patients who wanted to give something back. Some of these volunteers were asked to talk to patients about their experiences and offer support if needed.
- We were told how volunteers were often used with patients requiring extra support, and that recently a volunteer had spent time befriending a patient, with the support of the patients GP, in their home so they were able to further support them in hospital when the time came.
- We spoke with a volunteer who was helping to restock the linen cupboard. They said they felt valued working in the hospital and that all the staff were "Fantastic."

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good,

Service planning and delivery to meet the needs of local people

- Referral to treatment (RTT), under the NHS Constitution, patients in England says patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patient's should wait no longer than 18 weeks from GP referral to treatment. NHS England stopped the national target in June 2015. However, the hospital continued to treat the majority of its inpatients within 18 weeks of referral.
- From October 2015 to September 2016 the provider met the target of 92% of NHS patients on incomplete pathways waiting 18 weeks or less from time of referral. The highest of 95% being reached in December 2015.
- Between October 2015 and September 2016 the hospital did not meet target for patients with non-admitted treatment being seen within 18 weeks of referral. The lowest being 79% in February 2016 with a high of 92% in January 2016, compared to the target of 95%.
- The Horder Centre audits patient waiting times using a Patient Tracking List. This is a report that extracts information from the patient administration system into a spreadsheet. A designated member of staff filters through the report to audit waiting times for outpatients. All staff were aware of the need to meet the patient's 18-week pathway. A project team met twice weekly to discuss patient waiting times and discuss any areas of concern. Reports on compliance are shared with the local Clinical Commissioning Groups (CCGs).
- Patients were tracked on the hospitals computer system from arrival in main reception right through until they leave. This system allowed for staff to put a hold on a patient if they needed to visit the toilet and also tracked

them if they needed any x-rays or other diagnostic tests. This meant patients were reassured they would not miss their name being called and also gave consultants a real time account of their patients journey.

- The main outpatient's department reception area was open plan and well lit. Patients who arrived at reception were sign posted to their specific waiting area, which was nearest to the consultation rooms.
- During our inspection, we observed that there was adequate seating and no patients or relatives were standing.
- The outpatients waiting area had water available and comfortable seating. There was a screen visible to all with information on waiting times and which rooms particular consultants were in.
- There was a large free car park available for patients and patients we spoke to said it was never a problem finding a space.
- The department was clearly signposted and a hearing loop was provided at all reception desks for those who were hard of hearing.
- There were clear signs in areas where ionising radiation was used, this included lights and warning notices.
- We saw staff stopping to ask patients and visitors if they required assistance or direction, if they saw them appearing to be lost. Signage around the outpatient department was clear.
- Patients were informed they would be telephoned the evening before they were due to arrive for surgery giving them specific information on fasting times depending on their surgery times. This meant they were not fasting for longer than necessary.

Access and flow

- Access to outpatient appointments was reasonable and patients told us they were more than satisfied with the amount of time it had taken, to get the appointment. Patients also told us they were able to get appointments at times that suited them.
- NHS patients who used Choose & Book, and were subject to NHS waiting time criteria, were managed by the hospital's own administration team. NHS Patients were given three appointment times and could choose the most convenient, funded patients were able to choose a time and day that suited them best. We were told by the administration clerics that they would always try their best to accommodate every patient's needs.
- Outpatient clinics ran Monday to Friday 7:30am to 6:30 pm. These hours are extended if there is a requirement, we were told some consultants also offer Saturday clinics if there is a need.
- The hospital had very low 'did not attend' (DNA) rates. All patients who missed their appointment were followed up and offered a second appointment. If they DNA on the second appointment the hospital would contact the referrer who would be notified of the non-attendance, and would need to re-refer the patient.
- There was a process in place for managing referrals from General Practitioners (GP) and other healthcare organisations.
- The outpatient department had six consulting rooms, three minor operation rooms and one treatment room. They 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.
- Patients we spoke with felt appointments generally ran on time and that wait times were not a problem. We spoke to a patient who had accessed the services both as a private patient and as an NHS patient. They said there was no difference in the timeliness of appointments or the treatment they received.
- There was a Service Level Agreement in place between Horder Centre and the local NHS Trust. This is an NHS Contract for the provision of pharmacy services and is reviewed three yearly (last reviewed 2016).
- The NHS Pharmacy Team makes use of the existing pharmacy department area within the Horder Centre. An onsite pharmacy service was provided from Monday to Friday, 9.30am to 1.00pm and 1.30pm to 16.30pm. On Saturday, Sunday and Bank Holidays there was an emergency service only via the NHS on-call Pharmacist.

Meeting people's individual needs

Good

Outpatients and diagnostic imaging

- The PLACE score for disability (82%) was better than the England average. However, the score for 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.
- Place scores from the period February 2016 to June 2016 scored the hospital as better than the national average of 91% for food and organisational food, with scored of 96% and 94% respectively.
- The centre had introduced the butterfly scheme at the beginning of October. This is a dementia friendly scheme to make reasonable adjustments to plan services for those patients with dementia. Patients identified before attending hospital have a sticker clearly visible on their notes. We saw the training records for the staff who had attended the training. These included staff in the outpatients department and a staff member was in the process of becoming the link for patients living with dementia in the department.
- 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. Patients with specific additional needs are seen first in clinics to reduce waiting times and to make them feel at ease.
- We heard many examples in line with recommended guidance, NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.
- We were told of many examples where the staff went above and beyond to break down barriers and help patients who found it hard to access or use services. An example of this was making sure a patient who suffered anxiety was able to been seen at the end of the day when the waiting room was empty. Staff also ensured other patients were directed away from outpatients whilst she was attending. The patient was supported by staff from different departments and given ample time to allow her to spend time in the car park preparing herself for the appointment and being supported by family.
- We heard examples where volunteers who worked for the hospital were involved in getting to know anxious patients prior to their appointment so they could attend appointments with them to support them and help them feel at ease. This included supporting patients with learning difficulties and dementia.
- Staff told us they had access to a translation service. Staff gave us an example, where translation services were required for a pre assessment appointment, the translation services were then booked for the patients admission to the hospital and for the duration of their stay. This showed a commitment to ensuring patients understood their treatment and were supported to make decisions involving their care.
- 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.
- Bariatric patients were identified by staff when the referral was triaged. The hospital did not operate on patients with a BMI of over 40; however consultants would advise them on weight loss and see them again if they reached the maximum weight allowable. The hospital had couches and chairs for bariatric patients which were limited to a maximum weight.
- 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.

Learning from complaints and concerns

- We reviewed two complaints received by patients with reference to the outpatients department. Although there were actions as a result they were not specific to the complaint. For example as a result of one complaint it was acknowledged that there were lights in some waiting rooms that went off due to inactivity which could be distressing for any patient in the waiting room if this occurred. We could not see any action plan to remedy this although the complainant was informed as to why the lights went out.

Good

Outpatients and diagnostic imaging

- 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.
- 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 information of whom 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 Parliamentary and Health Service Ombudsman.
- Complaints were discussed at all levels from board to team meetings. The board were informed or the progress of on going complaints monthly, via key performance indicators. A nominated member of the board reviewed a random selection of complaints files every six months to ensure the process had been followed correctly and identified any learning in respect of the administration of complaints.
- Clinical complaints were reviewed at the clinical focus group. At monthly departmental meetings relevant complaints were discussed with staff.
- We saw a complaint which highlighted issues raised by patient that could have avoided with better communication between nursing staff and the patient. The complaint was discussed with staff in all departments involved, at their hub meetings. Actions from this complaint included reminding staff to ensure patients fully understood any post-operative instructions especially in connection with wound care.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good,

Leadership and culture of service

- Nurses, healthcare assistants and clerical staff all reported to the outpatient manager. 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 the executive team were visible and approachable and that they felt they could feed information up to the top as well as receiving feedback down.
- Regular meetings were held and incorporated all members of staff. These included weekly 'hub' meetings in each department. The multidisciplinary way in which staff worked within the hospital meant staff often attended 'hub' meetings for several departments. For example the occupational therapist attended the physiotherapy, outpatients and pre assessment hub meetings. This gave staff opportunity to be informed and updated about several departments within a week.
- The outpatient manger also managed the medical secretaries and bookings department which gave them a good oversight of the patient journey from start to finish. This also enabled them to see any issues arising from across many departments and identify trends early, regarding either staff or patients.

Good

Outpatients and diagnostic imaging

- The rate of outpatient nurse turnover was 11% from October 2015 to September 2016, a decrease of 3% from the previous reporting period. The rate of outpatient health care assistant turnover was 7% in the same reporting period, a decrease of 7% from the previous reporting period. This showed staff were increasingly stable and is an indication they were happy to work in the department.
- Staff told us they could approach immediate managers and senior managers with any concerns or queries this included staff behaviours and attitudes, although there had been no instances where this had been necessary.
- We saw staff that were open and honest about the things they would want to improve and things they felt proud about within the department. Staff told us they enjoyed working at the hospital.
- Sickness rates for nurses in outpatient departments were higher than the average of other independent acute hospitals for 7 out of the 12 months reported.
- Sickness rates for outpatient health care assistants were variable with five out of the twelve months from October 2015 to September 2016 showing higher sickness rates than the average of other independent acute hospitals we hold this type of data for.
- We were told new employees or underperformers are reviewed monthly. Managers addressed conduct and performance issues as they occurred through regular performance reviews and individual meetings. Occurrences of poor performance that are related to incidents or complaints are monitored on the risk management database.

Vision and strategy for this this core service

- Staff we spoke to were aware of the vision and values of the 'Horder way.' These included five core values of caring, friendly, quality, integrity and pride. We were told this also formed part of the interview process and that new staff have to demonstrate the values during interview workshops.
- 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 medical advisory committee (MAC) met bi-monthly. We reviewed the minutes of the last four meetings. The minutes showed the key governance areas such as complaints, incidents, health and safety and feedback from the clinical governance committee were discussed.
- The heads of departments (HODs) met monthly and the minutes of the last four meetings were seen. The minutes showed items discussed relating to outpatients and other departments including infection control, hospital activity, complaints and incidents.
- The outpatient department had a governance framework and reporting system in place. Regular monthly team meetings were planned and we saw evidence of these. However, these meetings did not always take place as planned. During our inspection we saw minutes of team meetings held in January, February and June 2016. Staff said that this issue had been identified and that monthly meeting were much better attended in recent months.
- The diagnostic imaging department was run by Medical Imaging Partnership carried out a variety of regular local audits to measure the quality of documentation these were then reported to the hospital through monthly department meetings in line with the LSA.
- Regular quality assurance tests were carried out on equipment to test the output of machines.
- The physiotherapy department used Patient Reported Outcome Measures (PROM's) to measure the quality of treatment interventions.

Governance, risk management and quality measurement

- The Clinical Governance Committee met alternate months and discussed incidents, complaints, infection control issues and risk register review. There was also a standing agenda item to review NICE guidance, to ensure the hospital implemented and maintained best practice, that ensured any issues affecting safety and quality of patient care were known, disseminated, managed and monitored. During our inspection we reviewed the minutes of clinical governance committee meetings held in May and July 2015 and January and April 2016.
- Horder Healthcare had a clear Risk Management Policy. Within this it clearly defined staff roles and expectations

with regard to reporting and responding to risk. This included a monthly review of managers' risk registers and a quarterly review of the corporate risk register. The Chief Executive has overall accountability for risk management.

- The outpatient manager was responsible for ensuring that all staff were aware of relevant policies and procedures and their role and responsibility in identifying and addressing all risk and safety issues. Staff we spoke with all had an awareness of the risk register and who to report any identified risks to within outpatients and diagnostics.
- There was a Risk Scrutiny Group (RSG) who provided assurance and identified high-level risks on the board assurance framework, corporate risk register and any risks escalated by departments. The RSG is chaired by the Director of Clinical Services. The outpatients and diagnostic department could escalate risks to be reviewed by the RSG which met quarterly. We saw evidence that there was an annual review of audit committee minutes by the Risk Scrutiny Group
- There was a robust system for identifying and reporting risk through the 'Horder Health Safety teams'. The safety teams were responsible for ensuring risks were identified and placed onto the electronic reporting system. The teams were also responsible for ensuring investigations take place and learning is disseminated. This included feedback from audits, Incidents, serious incidents requiring investigation and never events. They were also responsible for communicating any recommendations from the National Reporting and Learning System (NRLS), Health & Safety Executive (HSE), MHRA and other Alert Notices to all staff across the hospital.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience in outpatients by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data for all patients between July and December 2015 showed the hospital had consistently high scores (greater than 98%) and the response rates varied between 24.8% and 64%. The response rates for this period were the same as, or better than the average response rates for NHS patients in England. This showed that most patients were positive about recommending the department to their friends and family.
- The department also has an anonymous feedback questionnaire. This had a space for patients to write their details if they wanted a response.
- There was a touchscreen feedback stand situated near the reception desk in outpatients. Staff told us, they always encouraged patients to leave feedback, so they can try to continually improve services and standards of care. Although they had recognised there were low numbers actually taking the time to use the touchscreen. This had been identified and there was currently a review of the positioning of the stand. Staff had also felt that is was on a fairly unstable stand that may put off patients who were not steady on their feet.
- Staff were encouraged to recognise and celebrate success. We were told staff were informed by the HOD if they had been personally mentioned in any feedback from patients.
- During our inspection we saw several compliment letters and cards to the staff from patients, expressing their gratitude for the care and treatment they received during their visit to the department.
- There was a strong emphasis on promoting the safety and wellbeing of staff, this included a system that encouraged staff to take breaks away from computer screens. After a set period of time staff were reminded to take a break and offered the option of following desk exercises on screen. Staff said it was a useful tool, as it reminded them it was ok to take a break and that their wellbeing was being considered by management.
- Staff were all able to have breakfast, lunch and dinner at the hospital for free. They were also given free gym membership. This showed that staff needs were highly valued and appreciated. Staff were extremely positive about these inititives and felt their wellbeing was being considered by management.

Innovation, improvement and sustainability

- There were several outside areas and a therapeutic garden for patients and their relatives. This incorporated

sensory gardens, and areas the physiotherapists could use to aid patient recovery. For example different floor textures such as gravel and paving along with large and smaller steps.

- Ex-patients were invited to attend a patient focus group meeting. These aimed to create informal groups of people who shared the experience of having received surgery at the Horder Centre, both positive and negative. Ex-patients also received a newsletter, which invited them to give feedback and ideas on the running of the hospital.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital said it was the first Hospital to submit data through to the Private Hospitals Information Network (PHIN). PHIN is an independent, not-for-profit organisation that publishes trustworthy, comprehensive data to help patients make informed decisions regarding their treatment options, and to help providers improve standards.
- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- THC had successfully been accredited with venous thromboembolism (VTE) exemplar status. Organisations are awarded VTE Exemplar Centre status if they are able to demonstrate that they are delivering best practice as defined by the NICE Quality Standard for VTE prevention (QS3) and are taking an active role in their own local area in relation to disseminating best practice. For example, hosting VTE study days, educational events, contributing to publications and undertaking research).

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider the prominence of the hand gels to ensure their use by patients and staff.
- The provider should review it's policy on the use of Advance Decisions (AD) and ensure that staff are accurately recording information in patient records.
- The provider should ensure patient temperatures are measured during their operation in line with national guidance.
- The provider should ensure anaesthetic machine daily safety checks are recorded in the anaesthetic machine log book.However, completion of the anaesthetic machine checks was documented on the patients anaesthetic record.
- The provider should ensure mandatory training compliance meets the Horder Centre target.
- The provider should consider replacing the difficult intubation trolley to ensure it meets Association of Anaesthetists of Great Britain and Ireland guidelines.
- The provider should replace the shelves in theatres which have exposed wood.