# Rivers Hospital

## Quality Report

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

## Ratings

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Rivers Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 49 beds. Facilities include five operating theatres and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people (CYP), and outpatients and diagnostic imaging. We inspected all core services.

We inspected this service using our comprehensive inspection methodology. We carried out the short notice inspection on the 17,18 and 19 December 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

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

**Services we rate**

Our rating of this hospital improved. We rated Medicine, Surgery, Outpatients and Diagnostic Imaging as good and children and young people's services as outstanding. The hospital was rated as **Good** overall.

- The hospital provided staff with appropriate training to enable them to complete their roles and responsibilities.
- The hospital premises were visibly clean and well maintained. Surgical, outpatient, diagnostic and children and young people services managed infection control risks well.
- Equipment was well maintained and replaced as necessary.
- There were systems in place to support staff to assess patients' risks to ensure the safe provision of care and treatment.
- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- Medicines were stored, prescribed and managed safely.
- Safety incidents were managed using an effective system. There were processes in place to ensure shared learning.
- Staff were able to identify potential harm to patients and understood how to protect them from abuse. Services knew how to escalate concerns.
- The hospital provided staff with policies, protocols and procedures which were based on national guidance.
- Staff ensured that patients were provided with adequate food and hydration, offering varied diets to meet nutritional or religious preferences.
- Staff competency was assured through monitoring and regular appraisals.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Patients were supported to make decisions and were kept informed of treatment options. Staff treated patients with dignity and respect.
- Services were planned to meet the needs of the patients, with additional support available for patients who had additional needs.

# Summary of findings

- Services provided by the hospital were flexible to meet the needs of patients, enabling additional clinics, appointments or out of-hour services as able. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Complaints were taken seriously, with concerns being investigated and responses made within agreed timescales. Staff shared learning from complaints and encouraged patients to identify areas for improvement.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality child-centred care.
- Managers and leaders were appropriately skilled and knowledgeable to manage teams and services. Leaders were accessible and respected by staff.
- Managers promoted a positive culture which supported and valued staff, creating a sense of common purpose based on shared values.
- There was a hospital vision and strategy which was developed in collaboration with the clinical team and reflected a focus on patients and staff.
- The service had processes in place to monitor performance and used these to encourage staff to provide high standards of clinical care and treatment.

We found areas of outstanding practice in children and young people services:

- Parents' and children were extremely positive about the care and treatment they received. Feedback on the care, compassion and quality of the children and young people's services were unanimous in their praise for "for all aspects of the children's service". Six parents and two children who had experienced the day surgery pathway rated the service as ten out of ten and said, the service 'could not have been any better'.
- We were told nurses, consultants and support staff were always friendly and welcoming to children and their families and were skilled in communicating with children and young people which helped to minimise their distress. We saw examples where staff had gone the 'extra mile' to adapt the service in a safe but personalised way to better meet the needs of children and young people and their families.
- Staff involved children and their families at pre-assessment clinics where they were shown the type of equipment that would be used during their admission to hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had the equipment demonstrated on toys and were able to familiarise themselves with the equipment through play.
- Children and young people services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- Feedback from children and parents rated children's services as being between 95% and 100% for all aspects of care including, overall rating of care 100%, being looked after 100%, and the care by nurses, doctors and physiotherapists was rated between 94% and 100%.
- Areas used were dedicated solely for the use of children and had been adapted where possible to make them more appropriate for any age of child. For example, beds for children and young people had special bed linen and activities were provided to entertain and distract children of all ages.
- Children and young people had short waiting times prior to consultations or appointments.
- Children and young people's (CYP) services were overseen by a lead paediatric nurse (LPN) and a named consultant paediatrician. Staff told us the LPN had raised the profile of children's services and was recognised as being the clinical expert in the care of children and young people. Staff told us they were approachable and could be contacted for advice and support.
- Children's services were incorporated into the hospital vision and strategic direction for the hospital which was recognised by staff and integrated across children's services.
- The children and young people service actively engaged with children and their parents and families in feedback and development of children's services.

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

# Summary of findings

- The service did not monitor outcomes for oncology patients.
- Some policies provided were not in date or reviewed in line with the recorded timeline.
- Competencies within oncology were not always evidenced. For example, there was no evidence to support that pharmacists had completed oncology specific competencies and the head of department had self-assessed their skills.
- There were not always accessible handwashing sinks available in-patient rooms on the inpatient ward so staff could maintain good hand hygiene practices.
- Intravenous fluids were not always clearly prescribed or recorded.
- Some pain management audits were not always completed.
- A minority of patients did not always appear to have time between consent being completed and the date of operation.

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

**Amanda Stanford**

Deputy Chief Inspector of Hospitals (Central Region)

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Medical care** | Good | Medical care services were a small proportion of the hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.<br>We rated this service as good because it was safe, effective, caring and responsive, and well led. |
| **Surgery** | Good | Surgery was the main activity of the hospital.<br>Staffing was managed jointly with medical care.<br>We rated this service as good because it was safe, effective, caring responsive and well-led. |
| **Services for children and young people** | Outstanding | Children and young people's services were a small proportion of the hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.<br>We rated this service as outstanding because it was caring, responsive and well led. Safe and effective were good. |
| **Outpatients** | Good | Outpatient services were a small proportion of the hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.<br>We rated this service as good because it was safe, effective, caring, responsive and well led. |
| **Diagnostic imaging** | Good | Diagnostic services were a small proportion of the hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.<br>We rated this service as good because it was safe, effective, caring, responsive, and well led. |

# Summary of findings

## Contents

Good

# Rivers Hospital

**Services we looked at:**
Medical care; Surgery; Services for children and young people; Outpatients; Diagnostic imaging

# Summary of this inspection

## Background to Rivers Hospital

Rivers Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1992. It is a private hospital in Sawbridgeworth, Hertfordshire. The hospital primarily serves the communities of the Hertfordshire. It also accepts patient referrals from outside this area.

The hospital had a registered manager, who had been in post since July 2018.

The hospital provides outpatient consultations to both adults and children. The outpatient department comprises 17 consulting rooms together with three treatment rooms which are used for minor procedures. The hospital offers imaging and physiotherapy services in addition to a pharmacy department providing services for both inpatients and outpatients

All wards and departments are situated on the ground floor of the hospital. The operating facilities include five theatres and an endoscopy suite. All of the theatres have laminar flow.

There are 248 consultants working under practising privileges; and two anaesthetists employed by the hospital. There were 46.7 nursing and staff and 26.5 operating department and health care assistant staff across all departments. In addition, there were 68.7 health professionals, administrative and clerical and support staff who were shared across the hospital services and who were employed by the hospital.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital.

The hospital is managed by Ramsay Healthcare UK Operations Ltd; part of a network of over 30 hospitals and day surgery facilities and two neurological rehabilitation homes, across England. In addition, they own and run hospitals in Australia, Indonesia and France.

The hospital provides care for private patients who are ether paid for by their insurance companies or are self-funding. Patients funded by the NHS (approximately 60%), mostly through the NHS referral system can also be treated at Rivers Hospital.

The hospital undertakes a range of surgical procedures and treats adults and children. The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

The hospital was previously inspected in June and July 2016, when safe, caring and responsive were rated as good and effective and well led rated as requires improvement. The hospital had the overall rating of requires improvement.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, five other CQC inspectors and specialist advisors with expertise in surgery, oncology, outpatients, diagnostic imaging and governance. The inspection team was overseen by Phil Terry, Inspection manager and Bernadette Hanney, Head of Hospital Inspection.

## Information about Rivers Hospital

Rivers Hospital is a purpose-built hospital established in 1992. The hospital has 49 beds, 12 day case pods, five main theatres with laminar flow, 17 consultation rooms and an endoscopy unit with nine bays.

# Summary of this inspection

Rivers Hospital provides an inpatient and outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery, oncology, diagnostic imaging and urology.

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

- Diagnostic Screening procedures.
- Family Planning.
- Surgical Procedures.
- Treatment of disease, disorder or injury.

During the inspection, we visited the inpatient ward, theatres, endoscopy, day case areas (surgical and medical), outpatients and diagnostic imaging. We spoke with 68 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 40 patients and relatives including four children. During our inspection, we reviewed 44 sets of patient records and seven prescription charts.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected five times, and the most recent inspection took place in June 2016, when the hospital was rated as requires improvement overall.

**Activity (August 2017 to July 2018)**

- In the reporting period August 2017 to August 2018, there were 2,015 inpatient and 12,642 day case episodes of care, and 96,280 outpatient attendances recorded at the Hospital. There were also six inpatient children episodes, 281 children day case episodes of care and 2,886 children outpatient episodes.
- For the same period, approximately 49% of inpatient episodes, 68% of day case admissions and 57% of first attendance outpatient appointments were NHS funded.

248 consultants and anaesthetists worked at the hospital under practising privileges. A regular resident medical officer (RMO) worked on a weekly rota. The service employed 64.58 registered nurses, 34.14 theatre operating department practitioners and healthcare assistants, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the Head of Clinical Services (Matron).

**Track record on safety:**

- No never events.
- Clinical incidents: 534 no harm, 100 low harm, 21 moderate harm, no severe harm, two death.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- No incidences of hospital acquired Clostridium difficile.
- No incidences of hospital acquired E-Coli.
- 29 complaints.

**Services accredited by a national body:**

- Joint Advisory Group on GI endoscopy (JAG) accreditation.

**Services provided at the hospital under service level agreement:**

- Clinical and non-clinical waste removal.
- Cytotoxic drugs service.
- Pharmacy services.
- Nutrition and Dietetic services.
- Palliative care services.
- Interpreting services.
- Sterile services.
- Laser protection service.
- Laundry.
- Maintenance of medical equipment.
- Pathology and histology.
- RMO provision.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Good | Good | Good | Good | Good | Good |
| Surgery | Good | Good | Good | Good | Good | Good |
| Services for children and young people | Good | Good | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding | ☆ Outstanding |
| Outpatients | Good | N/A | Good | Good | Good | Good |
| Diagnostic imaging | Good | N/A | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

**Notes**

We do not rate effective for outpatients and diagnostic imaging.

Good

# Medical care

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

## Information about the service

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

Medical care services at Rivers Hospital consists primarily of a chemotherapy service and an endoscopy day unit service. The hospital is also able to provide haematology, rheumatology and cardiology care.

Oncology services were delivered on Meadow ward (surgical ward) whilst a dedicated chemotherapy unit was being built and due to open in January 2019. The new dedicated Chemotherapy Unit contained 7 dedicated bays and a single room for patients should they need to be admitted for longer treatments. The unit was purpose built for chemotherapy & haematology patients who are currently treated in private rooms. Services are currently offered Monday to Friday, with a 24-hour telephone line for chemotherapy patients.

The endoscopy unit has one theatre and nine patient bays. Services were offered Monday to Friday and on a Saturday once every six weeks.

### Are medical care services safe?

Good

Our rating of safe stayed the same. We rated it as good.

**Mandatory training**

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it. There were processes in place to monitor training compliance.**
- The hospital had 24 mandatory training modules that were a mixture of practical sessions and e-learning. Mandatory training sessions covered modules such as fire safety, health and safety, infection control, hand hygiene, basic life support, safeguarding, sepsis and dementia. The hospital business plan for 2018/19 identified the need to improve training rates to 90% by the end of the year (April 2019). Overall training figures provided at the time of the inspection for both oncology and endoscopy were above the target at 95.6%.
- Managers had access to an electronic training record, which detailed staff training status. Managers used this to monitor and improve performance with training compliance.
- Staff were given protected time to complete mandatory training and could access the e-learning at home should they find it difficult to complete at work. Staff could claim the hours back.
- A staff training plan from October to December 2018 was visible throughout the hospital to staff and included training sessions such as incident reporting, dealing with difficult customers and an overview of cancer.

**Safeguarding**

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- The hospital had policies and procedures in place to safeguard children and vulnerable adults at risk of

abuse. Nursing staff demonstrated how they located policies on the hospitals intranet system. We saw safeguarding information on a display board. It provided information for staff about what to do if they had a safeguarding concern. There were also display boards in the hospital to promote dementia awareness to staff.

- The hospital established the level of safeguarding training needed for staff based on their job role and type of contact they had with patients. At the time of our inspection 100% of staff in oncology and endoscopy had completed level two in safeguarding adults and 85.7% had completed level two in safeguarding children. Staff who cared for young people aged between 16 to 18 years were trained to level three in safeguarding. Endoscopy services were not provided for children and young people under 16. We were assured that staff in endoscopy who had contact with young people had received the appropriate level of safeguarding training. Managers actively managed staff training performance.
- The safeguarding leads for children and adults were known to staff and visible around the hospital. This included staff with safeguarding level four training. One staff member described a safeguarding concern and how they sought advice from the lead.
- Staff had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. Nursing staff could describe and demonstrate how they would respond to a safeguarding concern, using real examples of concerns they had effectively escalated and referred to local safeguarding services.

**Cleanliness, infection control and hygiene**

- **The service generally controlled infection risk well and used control measures to prevent the spread of infection. Staff generally kept themselves, equipment and the premises clean.**
- **The temporary environment in which chemotherapy was being delivered, impacted on the services ability to maintain effective and visible infection control practices, however, we did not see any impact of this on patients care and treatment.**
- At our last inspection in July 2016, we found that infection control audit results were not always shared consistently with staff. During this inspection staff were aware of audits in place and we saw evidence in ward meeting minutes for August and September 2018 that the audit outcomes were shared with staff.
- Infection control training was mandatory for all staff, however not all staff had completed it. Endoscopy staff were 70% compliant and oncology staff 90% compliant. At our last inspection in July 2016, the service was not compliant with infection control training targets of 95%, with 80% of staff completing the training. This demonstrates improvement within oncology but a decline in compliance within endoscopy.
- We saw variable compliance with handwashing. We did not observe staff completing regular hand washing practices between patients attending for chemotherapy. There were limited handwashing facilities for staff to wash their hands on the ward where chemotherapy was temporarily being delivered. We saw one nurse wash their hands after disposing of personal protective equipment (PPE) following administration of treatment. We observed three missed opportunities for hand washing after patient contacts, however, handwashing facilities were not available in the patient rooms; therefore, it was difficult to fully assess compliance. The new chemotherapy unit was designed with several hand washing sinks accessible and visible throughout the unit.
- Regular hand washing was observed between patient contacts in endoscopy. We saw three staff washing their hands following an endoscopic procedure and then two staff washing their hands following a patient contact in recovery.
- Staff were generally compliant with their arms 'bare below the elbow'. However, we saw two nurses wearing rings with a stone, in both oncology and endoscopy. We saw the hospital wide hand hygiene audit results for July 2018. This was based on 10 observations and covered areas such as hand decontamination, hand washing techniques and compliance to policy. The average results were 95%. The audit identified actions including: staff being reminded of the uniform policy; requesting rings to be removed when noted; outcomes to be discussed at mandatory training and the infection control committee meeting.
- Clinical areas within endoscopy and the ward where chemotherapy was being administered, were mostly clean and tidy. However, some areas we checked were not cleaned effectively, for example we found dust on recovery bay dividers in endoscopy. We raised this with the endoscopy lead nurse who told us they would arrange for domestic staff to clean the area.

- Personal protective equipment (PPE) was used by staff in both endoscopy and oncology, including protective aprons and gloves when undertaking clinical procedures. Whilst PPE was available, it was not easily accessible to staff in the oncology service.
- PPE was generally disposed of in appropriate clinical waste bins after use. However, during the inspection we saw a clinical waste bag attached to a trolley, used by oncology staff, in the ward corridor. This was used to dispose of PPE following administration of chemotherapy and was not appropriately covered or secured. This was brought to the attention of the hospital matron and it was removed immediately.
- Waste was appropriately segregated in clinical areas with separate colour coded arrangements for general waste, clinical waste and sharps (needles). Bins were clearly marked and within safe fill limits. Date of opening of sharps bins were completed on all bins we observed.
- The chemotherapy service used purple sharps bins to dispose of cytotoxic (cytotoxic drugs are used for cancer treatments to help prevent growth of cancer cells) waste.
- Spill kits were readily available in endoscopy and oncology which allowed staff to safely collect and dispose of bodily fluids including blood and urine. Specific spills kits were accessible to oncology staff to clean and dispose of cytotoxic waste and spillages. Staff were aware of the precautions when handling cytotoxic medications and waste.
- Antibacterial hand gel was available throughout the hospital including the endoscopy department and Meadow ward, where chemotherapy was being administered. We saw signs to encourage staff, patients and visitors to wash their hands and use hand gel.
- Deep cleans were arranged following the discharge of patients with an infection and rooms used for patients attending for chemotherapy were cleaned before use. Patients attending endoscopy with known communicable infections were seen at the end of the day to reduce the risk of infection spreading. Deep cleans were completed after discharge.
- The oncology service had no reported acquired infections associated with peripherally inserted central catheters from January to December 2018. Peripherally inserted central catheters is a common procedure for patients receiving chemotherapy.
- Quarterly air quality assessments were completed to assess the risk of decontamination of chemotherapy medications in the cytotoxic suite in the pharmacy. We looked at the reports from October 2017 to October 2018 and all passed the assessment, meaning that the service had measures in place to ensure that the preparation of cytotoxic medication was safe and low risk of contamination.
- Processes were in place to ensure that decontamination of endoscopic equipment was adhered to. All endoscopes used were documented and traceable. Once cleaned, endoscopes were transferred to a clean area through a machine. Clean endoscopes were placed in sterile, seven-day storage cabinets and stored appropriately. Staff working in the decontamination area wore appropriate disposable gowns and face shields.
- Disposable curtains in the endoscopy recovery area were changed in accordance to the hospital's policy.

**Environment and equipment**

- **The premises were not always suitable however the hospital had plans in place to improve the premises for patients. Equipment was looked after well and maintained.**
- During our last inspection in July 2016, concerns were raised about the potential risks to health and safety due to the administration of chemotherapy in some carpeted areas in patient bedrooms. The hospital took immediate action to provide four non-carpeted bedrooms immediately after we raised this. We observed that all chemotherapy treatments were being administered in appropriate non-carpeted bedrooms. This concern was also identified on the hospital risk register.
- The oncology service did not have suitable space and facilities. Whilst the environment was generally well maintained it was not always suitable for all types of care and treatment being provided by the chemotherapy service. For example, chemotherapy was administered to patients in individual patient rooms, with preparation materials stored on an unsecured trolley in the corridor.
- At the time of the inspection, the oncology service was in the process of moving into a purpose-built chemotherapy unit with seven dedicated chemotherapy bays. As an interim measure, treatment was being administered on a surgical ward in four single

occupancy rooms. These rooms were used by the surgical ward when not in use by the chemotherapy service. Staff told us that it was sometimes difficult to ensure a room was available to administer treatment.

- Equipment had been checked and tested in both oncology and endoscopy. Resuscitation trolleys, which contained medicines and equipment required in an emergency, were accessible in the endoscopy unit and the ward where chemotherapy was being delivered. However, a resuscitation trolley situated on Orchard ward was not securely sealed, which meant that it was possible the trolley could be tampered with by an unauthorised person. This was brought to the attention of staff and immediately sealed. Resuscitation trolleys were checked daily to ensure they were stocked, equipment was in working order and medicines were in date. Equipment on the trolleys, such as the defibrillator, were portable appliance tested and the oxygen cylinders were full.
- Legionella testing was completed every three months and pseudomonas testing monthly. Minutes of the September infection prevention and control committee confirmed that neither legionella or pseudomonas was detected in the August 2018 water test.
- Monthly water sampling was completed in endoscopy by an external provider. Test results from July to December 2018 indicated a positive sample of unconfirmed pseudomonas in one of the automated endoscope repressor (AER) machines. An AER is a machine used to wash and decontaminate equipment used for endoscopic procedures. The AER machine was taken out of service and during our inspection, we were advised that the service was in the process of purchasing a new AER machine.
- In August 2018, both AER machines were out of service, resulting in a cancelled theatre list. We were assured the service had effective systems in place to manage this and were in the process of fixing the machine. A local risk assessment was in place and there was a robust contingency plan within the endoscopy operating procedures.
- There were processes and procedures in place for tracking equipment used for each patient's endoscopic investigation. This included sterile equipment used for biopsies and details of staff members who operated and decontaminated the equipment. Following its use, the equipment was decontaminated and stored appropriately. The endoscopy staff monitored the decontamination system daily, ensuring that there was sufficient clean equipment to meet the demands of the service.
- The endoscopy unit was generally well maintained. For example, air handling units had been upgraded over the 12 months prior to the inspection in endoscopy to improve air quality within the unit.
- Both the endoscopy and oncology units had up to date control of substances hazardous to health (COSHH) risk assessments in place to support staff's exposure to hazardous substances.

**Assessing and responding to patient risk**

- **Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Assessments were in place to alert staff when a patient's condition deteriorated.**
- The hospital had processes in place to assess the risk to patients using the service and developed risk management plans in line with national guidance. Risk assessments were carried out at pre-assessment, upon admission to hospital and throughout the patient pathway.
- An admission policy was in place that set out guidelines for the safe admission of patients. A nurse-led pre-admission risk assessment was completed for all patients in both chemotherapy and endoscopy.
- Patients bloods were taken on site and sent to the on-site pathology lab for analysis. Some blood tests such as blood cultures were sent off site. Staff could access these blood results easily using an online portal.
- Processes were in place to ensure safe admissions for treatment. Admissions were not accepted unless the patient was under the care of an appropriate consultant who had practising privileges at the hospital. The endoscopy and chemotherapy units did not accept emergency or unplanned admissions.
- We observed an endoscopy procedure taking place. Patients risks were managed by trained staff in the endoscopy treatment room. There was a consultant, decontamination staff and a trained nurse present for the procedure. Trained staff and health care assistants looked after the patients in bays prior to and following the procedure. Staff were trained and competency assessed to assist in the procedure.
- Processes were in place to identify, monitor and manage a deteriorating patient and all staff had

received sepsis training. The hospital used the National Early Warning Score (NEWS 2) for all patients in line with the National Institute for Health and Care Excellence (NICE) guidelines relating to recognising and responding to the deteriorating patient. We reviewed 10 oncology patient records and three endoscopy records. All had evidence of NEWS 2 being completed and observations being completed prior to, during and after treatment or procedures.

- There was a deteriorating patient policy in place which included guidance and treatment pathways for sepsis such as sepsis six guidance. There was a separate neutropenia policy that set out clear guidance for monitoring and managing the risk of neutropenic sepsis. Neutropenic sepsis is a potentially fatal complication of anticancer treatment (particularly chemotherapy). Chemotherapy staff understood the risks and could describe how they would manage a patient with signs of neutropenic sepsis. Staff accessed an algorithm based on the national institute for clinical excellence (NICE) guidelines regarding treatment of neutropenic sepsis, this included frequency of observations and antibiotic administration.
- There was a process in place to support patients, should there be any concerns out of normal opening times. A 24-hour telephone advice service operated for chemotherapy patients and processes were in place to triage patients that called. During the day, chemotherapy nurses used the United Kingdom Oncology Nursing Society (UKCON) triage tool when answering calls. Out of working hours the ward staff answered the telephone. The chemotherapy nurses provided staff with a triage form to complete and document advice provided and actions taken. The forms were kept in a folder that was securely stored and reviewed by the chemotherapy nurses.
- Ward staff were not trained to use the UKCON triage but would triage the call and contact the chemotherapy lead, consultant or registered medical officer (RMO) to seek advice if necessary. A feedback form was completed by staff and placed in a folder so the chemotherapy nurses could see what action was taken the following day. The chemotherapy nurses told us they intended to train ward staff to use the UKCON triage tool once they moved into their new unit. Patients were provided with a 'chemo patient diary' that contained information about how to make contact between treatments.
- The hospital had a critically ill patient transfer policy for patients who deteriorated and needed a higher level of care than that provided by the hospital. There was a service level agreement with a local acute NHS trust to transfer patients by ambulance if required. Staff we spoke to in the endoscopy and chemotherapy units described how they would manage a deteriorating patient who required transfer. Staff told us this was rare and if this happened it would be recorded as an incident.
- The hospital had an extravasation policy in place however during the inspection we came across two extravasation policies. Extravasation is a term used when medicines that are being administered intravenously (such as chemotherapy) unintentionally leak into the surrounding tissue and cause damage. One policy was dated 2013 and was in the extravasation kit on the ward. One was dated 2018 and was provided to us by the hospital upon request. Both policies had different content in terms of medications to be administered in the event of extravasation. The most up to date policy did not reflect the contents of the emergency extravasation kit. This was raised with the hospital during the inspection. Following the inspection, the hospital informed us that they had investigated the concerns raised and would be updating the extravasation kit to reflect the most up to date policy. We were advised that the chemotherapy nursing staff had been updated on the new policy and changes in the medications in the extravasation kit.
- Staff had a good knowledge of the process, treatment, and the importance of recognising the early symptoms of extravasation. There was one reported extravasation incident in 2017, that was identified quickly by nursing staff administering treatment. The incident report indicated the patient was reviewed by the consultant, treated and admitted for close monitoring. During the inspection, we observed staff checking the skin following treatment commencing for signs of extravasation. The emergency kit was in the treatment room on Meadow ward and there was evidence of it being regularly checked.

**Nurse staffing**

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**

- The oncology service was staffed with three trained nurses including a chemotherapy lead nurse, a clinical sister and one nurse who provided chemotherapy care. During the inspection, one of the nurses was on maternity leave and a chemotherapy experienced bank nurse was used for cover. Permanent staff were appropriately skilled and had completed training from specialist oncology courses at recognised clinical training centres.
- The clinical lead for chemotherapy was available weekdays and out-of-hours patients were advised to contact the ward or their consultant directly. A breast cancer specialist nurse worked alongside the chemotherapy nurses and saw patients whilst in for treatment. Staffing was reviewed every six months and the hospital planned to increase staffing to support an increase in patient capacity once the service located to the new unit.
- Processes were in place to ensure patients safety in the event of unexpected staff absence. Both endoscopy and oncology had separate briefings in the morning to discuss patient lists for the day and if necessary capacity issues were communicated with the hospital matron. Healthcare assistants occasionally supported the service dependent on the numbers of patients and level of complexity. During the inspection, a healthcare assistant was supporting trained nurses in oncology due to short term sickness.
- The endoscopy service formed part of the wider theatres service and staffing was managed along with theatres. Daily staffing levels were written on the whiteboard in the department. There was an endoscopy lead and a senior sister along with trained nurses and health care assistants. The service used a regular bank nurse and theatre nurses to cover unfilled shifts and unplanned absence.

**Medical staffing**

- **The service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.**
- Oncology consultants were largely drawn from the local NHS hospital which enabled close working relationships and the sharing of services. Consultants were expected to formally apply for practice privileges and the hospital assessed their training, scope of practice, qualifications and GMC registration.
- Consultants with practising privileges were required to be contactable always when they had a patient at the hospital. Oncology nursing staff told us that they could call and speak with the consultants at any time for advice and if required the consultant would come into the hospital to see a patient.
- At the time of the inspection there were eight consultants with practice privileges working within oncology and eight consultants working within endoscopy.
- Chemotherapy treatment was consultant led and all patients were discussed at a multidisciplinary team meeting (MDT) to agree a treatment plan. MDTs were held at Rivers Hospital or at an MDT in an acute trust where the consultant was based. An oncology consultant confirmed they had good working relationships with the chemotherapy nurses and pharmacist in managing safety effectively.

**Records**

- **Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care. All records in endoscopy and oncology were kept in locked cupboards to maintain confidentiality.**
- At our last inspection in July 2016, medical summaries in some chemotherapy patient records were sometimes illegible. During this inspection we did not find any consultant hand written records in the 10 records we checked. Chemotherapy consultant records were in the form of a contemporaneous dictated clinical letter to the general practitioner (GP) that was produced and sent out on the day of the appointment. The letter provided a diagnosis, treatment plan, medication regimes and follow up required. We were advised by a consultant that records were dictated and filed in the form of a letter. All nursing entries were legible and concise.
- At our last inspection in July 2016, patient records in the endoscopy unit were not always stored securely. During this inspection we observed endoscopy records being securely stored in lockable draws behind the nurse's station. Chemotherapy records were also stored in a lockable container.

- Patient's individual care records were written and managed in a way that kept them safe. Records contained individual risk assessments, observations and notes from day admissions. Records were well organised and legible for both endoscopy and oncology patients.
- We reviewed 10 oncology records and all had a chemotherapy visit care pathway that included a pre-treatment assessment, admission record, patient contact record and a discharge checklist. Records were mostly completed; however, the discharge summary had not always been completed for patients that had been discharged following chemotherapy.
- We reviewed three endoscopy records. All records had an endoscopy pathway and safety checklist that included a comorbidity checklist, pre-operative complications checklist, pre-operative assessment, admission assessment, care provided, traceability log and discharge checklist. All records reviewed were up to date, clear and legible. We saw evidence that equipment used for the endoscopy procedure was traceable and recorded on the patient record and centralised log.
- Chemotherapy records were audited quarterly. The November 2018 audit showed a good level of compliance with record keeping. Good practice included the 100% completion of consent to treatment and care pathways. Staff identified a need to improve completion of the patient self-assessment form.

**Medicines**

- **The service generally prescribed, gave, recorded and stored medicines well.** Patients received the right medication at the right dose at the right time.
- Arrangements for prescribing, handling, dispensing, administration, and disposal of medicines kept people safe. However, intravenous (IV) fluids were not stored securely in the chemotherapy service. For example, we found several IV fluids in a draw on an unsecure trolley in a corridor being used by the oncology service. We raised this with the matron who advised us they would be removed immediately. During the inspection, we visited the new chemotherapy unit and were assured that there were adequate and secure storage facilities for IV fluids.
- Pharmacy services were available on-site Monday to Saturday. An out of hours on-call service was available. The pharmacy service prepared chemotherapy medications onsite and transported these to the ward ready for administration. The pharmacists worked closely with consultants and chemotherapy nurses to ensure the safe administration of cytotoxic medications.
- Cytotoxic medications were reconstituted in the onsite pharmacy. Cytotoxic medications were safely stored in a locked aseptic room or a cytotoxic lockable fridge, demonstrating improvements made following our previous inspection in July 2016.
- Cytotoxic drugs are subject to safety restrictions issues by the Health and Safety Executive (HSE). The safety risks were outlined in the service risk register and the service was compliant with the HSE regulations. For example, there were policies and procedures in place and PPE was available to staff. We saw evidence that nursing staff handling cytotoxic medications were trained in the management of cytotoxic exposure.
- We looked at five chemotherapy patient medication charts and found them to be completed appropriately. Weight and allergies were recorded and there was evidence that they had been checked by the pharmacist.
- Medications were stored securely in line with the hospitals guidance. Medications requiring cool storage were stored appropriately by nursing staff and records showed that they were kept at the correct temperature in a lockable fridge in a treatment room. Medications in the endoscopy treatment room were in a locked cupboard and recorded in accordance with the hospital's documentation.
- Controlled drugs used within the endoscopy unit were stored securely in a locked cupboard in the treatment room. Staff told us they checked the controlled drugs daily. Following the inspection, we were provided with the latest controlled drug audit. The audit demonstrated 100% compliance with the hospitals medicines management and controlled drugs policies.
- Sedation given in the endoscopy unit was administered based on national guidance and individual needs. We reviewed three endoscopy patient pathways; all clearly identified type of sedation and medications given which were recorded on drug charts.
- There were no chemotherapy medication incidents reported from 01 July 2018 and 31 December 2018.

**Incidents**

- **The service managed patient safety incidents well.**

Good

# Medical care

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff used an electronic incident reporting system to submit incident reports. All staff we spoke to said they had been trained and were confident in the use of this system. The hospital had rolled out a risk management and lessons learnt training to staff.
- There had been no never events in the reporting period between July 2017 to June 2018 in the endoscopy or oncology services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Two incidents were reported between June and December 2018 in endoscopy. The incidents related to complications during and after the procedure. The service provided us with reports that demonstrated both incidents were dealt with at the time and fully investigated. The service demonstrated they acted following lessons learnt. For example, an instrument used for a procedure was taken out of service and replaced to reduce the risk of the incident happening again.
- Following the inspection, the service advised us there were no incidents reported between June and December 2018 in the oncology service relating to chemotherapy treatment.
- Senior staff explained how they would investigate incidents and cascaded them to the staff team for shared learning. Staff confirmed that incidents were discussed at ward meetings. For example, staff in endoscopy could describe two recent incidents that happened in the department. Staff we spoke to were also able to describe recent incidents that had occurred in other departments across the hospital; demonstrating positive learning from all incidents.
- A patient's death reported was an expected death of a chemotherapy patient. The patient's condition deteriorated and was admitted for end of life care at Rivers Hospital. The death was appropriately reported, fully investigated with lessons learnt.
- The hospital reported one serious incident between July 2017 and June 2018 relating to the endoscopy service. A root cause analysis was completed and lessons were learnt. There was evidence of duty of candour regulation being followed and an apology was given to the patient and relatives.
- From November 2014, providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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 the person. Nursing staff understood their responsibilities regarding the duty of candour legislation. They said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology. We saw evidence that the duty of candour regulations was followed in the incident reports we reviewed.
- Feedback from incidents was shared with staff. Staff in both endoscopy and chemotherapy told us they received feedback via email for incidents they raised but also received feedback in ward meetings. All staff were aware of the 'ten at ten' meeting. This is where senior managers briefly discuss hospital matters, including incidents, and feed this back to staff. We saw evidence of incidents and lessons learnt to be discussed in head of department meetings and staff could tell us about recent incidents and lessons learnt.
- Rivers Hospital had rolled out the 'big up for safety' campaign. Workshops were being delivered for all staff including endoscopy and oncology staff, to improve communication, openness and challenge when patient safety concerns are identified. Incidents and lessons learnt were shared at the workshops to encourage a more open culture of reporting.

**Safety Thermometer (or equivalent)**

- **Please see the surgery report for details for safety thermometer.**

## Are medical care services effective?

Good

# Medical care

Good

Our rating of effective improved. We rated it as good**.**

**Evidence-based care and treatment**

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- The service followed nationally recognised guidance and standards relating to patients' safety. We saw policies and procedures in place. Staff told us they could access policies on the intranet. There were systems in place for reviewing policies and staff were communicated with when there were updates via email or through ward meetings.
- The service had evidence based policies and procedures in place, however, it was not always clear which policy was being used. During our inspection we reviewed chemotherapy based policies including the neutropenia policy, extravasation policy and systemic anti-cancer therapy (SACT) handling and administration. The extravasation policy in the extravasation kit did not reflect the most up to date corporate policy. However, following the inspection, we were told that the chemotherapy services had been restructured in November 2019, and the teams were working through the new governance structure. The senior management team told us that they communicated the most up to date policy to oncology staff. They also updated the medicine contents in the extravasation kit to reflect the updated policy. The SACT and neutropenia policy were in date.
- Policies and processes relating to cancer care were based on the national institute for healthcare excellence (NICE) and UK oncology nursing society (UKCONS) guidelines. Endoscopy policies were evidence based, for example they followed the British society of gastroenterology guidelines.
- Staff used defined pathways based on national guidance to ensure treatment and care was delivered based on individual need. For example, patients who received chemotherapy and endoscopy had specific care pathways.
- The endoscopy service used a modified version of the World Health Organisation (WHO) five steps to safer surgery checklist. Staff conducting procedures were required to confirm the patient's name, age, procedure site and consent before starting treatment and record that this had been done on the checklist. During the inspection, we observed a patient undergoing the checklist and consent process. We looked at five sets of patient records and found staff had fully completed the WHO checklist in each patient record.
- A review of ten oncology records indicated that the service assessed patients physical, mental health and social needs prior to treatment starting. Patients were reassessed at each visit using the chemotherapy visit care pathway tool. Treatment pathways were in line with NICE guidelines and the UKCON standards.

**Nutrition and hydration**

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- Pre-admission information for patients provided clear instructions on fasting times for food and drink before endoscopy procedures. Records showed checks were made to ensure patients had adhered to fasting times before procedures went ahead.
- Patients with diabetes who were treated in the endoscopy unit had blood sugar checks before and after each procedure. This meant risks relating to blood sugar levels were managed appropriately.
- The oncology service assessed patients' nutritional needs and risks during the pre-assessment. This included the identification of malnutrition risks due to illness, co-morbidities and special dietary requirements. Patients who were identified at risk of malnutrition were referred to the dietician.
- Chemotherapy patients with nausea or vomiting were assessed and prescribed antiemetic medicine (a drug effective against vomiting and nausea). Antiemetic medication was prescribed prior to chemotherapy treatment starting for oncology patients.
- Patients attending the oncology and endoscopy departments were not generally in the department for long periods. Tea and toast was provided to patients in endoscopy who had fasted prior to endoscopy procedures. Food menus were in patient rooms in oncology. Patients could order food; both patients and visitors were offered drinks.

- There were water coolers and hot drinks machines around the hospital for patients and visitors to help themselves. We observed that staff offered drinks to patients and visitors and assisted them if required.

**Pain relief**

- **The service managed patients' pain effectively and provided or offered pain relief when required.**
- The service met the Faculty of Pain Medicine (2015) Core Standards for Pain Management Services. Chemotherapy patients with acute pain had an individualised analgesic plan and staff conducted regular pain assessments using appropriate tools. Nursing staff communicated any concerns with pain management to the patients' consultant who would then review the patient.
- Pain was regularly risk assessed and recorded using the National Early Warning Score (NEWS 2) scale and we saw these were completed for chemotherapy patients during treatment.
- **Please see surgery report for further details of pain relief.**

**Patient outcomes**

- **The service monitored the effectiveness of care and treatment and consistently used the findings to improve them. However, the oncology service did not participate in any clinical effectiveness audits.**
- The service did not collect information regarding outcomes for patients who received chemotherapy. There were no specific audits for oncology services, for example, a neutropenic sepsis audit. This meant that we could not be assured the oncology service had oversite of the service being provided. Oncology staff told us they intended to improve the level of audits completed once they moved into their new unit.
- The endoscopy service had maintained its Joint Advisory Group Gastroenterology Society (JAG) accreditation (March 2018). This meant the endoscopy unit and its staff were assessed and monitored for quality performance and clinical safety against established international benchmarks. JAG accreditation was monitored through quality checks annually. For example, completion rates of endoscopy procedures were collected and audited regarding patient outcomes. The service also audited their decontamination procedures.
- Patients were offered treatment alongside chemotherapy to reduce the side effects of treatment. For example, patients were offered scalp cooling. Scalp cooling is a treatment that can prevent hair loss caused by some chemotherapy drugs. The service had two scalp coolers and it was offered to patients to reduce or prevent hair loss during chemotherapy treatment.
- The lead pharmacist for oncology and a pharmacy technician conducted regular aseptic audits for chemotherapy services using microbiology protocols. This helped to ensure patients were treated in a safe environment. At the time of our inspection, audits indicated practice adhered to the hospital's best practice policies.
- The chemotherapy lead told us they intended to become accredited with the Macmillan cancer support charity once they moved into their new unit. The Macmillan Quality Environment Mark (MQEM) was introduced by the charity in 2009 to assess whether cancer care environments met the standards expected by patients undergoing treatment for and living with cancer.

**Competent staff**

- **The service generally made sure staff were competent for their roles.** Managers appraised staff work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- At out last inspection in July 2016, we found that competency checks for pharmacists working in chemotherapy services were not always documented. During this inspection, pharmacy staff told us they were provided with time to attend training specific to oncology. Following the inspection, we were provided with a list of British Oncology Pharmacy Association (BOPA) competency standards that pharmacy staff were measured against. However, we were not provided with evidence that pharmacy staff had been competency assessed against them. Therefore, we could not be assured that improvements had been made since our previous inspection.
- Processes were in place to ensure staff were signed off as competent in oncology and endoscopy. Staff underwent both a generic and service specific competency assessment and we saw evidence that this

was completed. However, the chemotherapy lead competencies were self-assessed as competent but had not been signed off by another suitably qualified person.

- Processes were in place to induct and train temporary bank staff. An orientation and induction checklist was used for bank staff new to the hospital which we saw in place in endoscopy. Endoscopy were using one bank staff and two theatre staff to cover shifts due to vacant positions. Bank staff in endoscopy had been signed off as competent. Two bank staff were being used in the oncology service and had an up to date competency assessment. All staff working in oncology has completed a five day nationally recognised course in oncology.
- Staff knew how to access their competencies and understood the expectations. An endoscopy staff member showed us their competency folder which was up to date and signed off by a manager. The endoscopy lead told us that staff competencies for endoscopy were up to date. Following the inspection, we were provided with a copy of completed competencies for three staff including a bank staff member working in the unit.
- The service provided opportunities for staff to attend external training and skill sessions. For example, oncology staff attended a haematology conference and endoscopy staff have external study days for use of endoscopes.
- Oncology staff shared learning well with other services; they designed a temporary neutropenic sepsis board to educate staff about the signs and symptoms for patients undergoing chemotherapy.
- Oncology staff were in the process of completing the United Kingdom oncology nursing society (UKONS) passport. The UKONS passport is a competency assessment for oncology nurses for the safe handling and administration of anti-cancer therapy.
- Staff within oncology had undertaken additional training relevant to their role. This included, dealing with emotional stress and living well with cancer. They had also completed scalp cooling training. Scalp cooling is used to help reduce or prevent hair loss caused by chemotherapy.
- Staff who worked in endoscopy and chemotherapy services had an annual appraisal from a senior member of staff. Compliance with this was 66% for endoscopy staff and 100% for oncology staff. For the endoscopy service, this demonstrated a reduction in compliance with the annual appraisal process since our last inspection in July 2016. During the inspection all staff we spoke with said the appraisal process enabled them to focus on professional development.
- **Please see the surgery report for details of medical competencies.**

**Multidisciplinary working**

- **Staff worked together as a team to benefit patients.**
- Doctors, nurses, pharmacists and other healthcare professionals supported each other to provide patient care. For example, we observed effective working relationships between chemotherapy nurses and pharmacy staff in responding to patients changing needs in relation to their treatment.
- Nursing staff in both oncology and endoscopy had positive working relationships with consultants. They felt confident to contact a consultant as required if they had any concerns regarding a patient's care and treatment. During the inspection we observed positive interactions between consultants and staff, demonstrating effective team working.
- The breast care specialist nurse worked closely with the chemotherapy nurses and consultants in delivering effective patient care. Regular communication between them improved the continuity of care for patients from clinic, to assessment and treatment starting.
- Oncology consultants held regular multidisciplinary meetings of their patients at a local hospital with appropriate specialists. This was used to coordinate care for patients with co-morbidities and who were under the care of more than one health professional. Staff told us they received verbal feedback from the consultants from the meetings, however, the meetings were not documented. Therefore, we were not assured that that the information provided regarding patients was accurate and up to date.
- We were advised by staff that there was a specialist breast cancer multidisciplinary team (MDT). Following the inspection, we were provided with evidence that all new referrals were discussed at an MDT meeting and the outcome, including treatment plan was fed back to the oncology service.
- Chemotherapy nurses had daily handovers with ward staff providing an overview of chemotherapy patients

treated and any concerns shared. Ward staff fed back any issues that happened over night or at the weekend by logging it on an online system or recording it in a triage folder.
- The chemotherapy and endoscopy leads at the hospital shared information and experiences with respective leads in other Ramsey hospitals.
- Discharge plans included information sent to the patient's GP and referrals to other community services, such as local hospices, for ongoing care. However, discharge plans were not always completed following treatment for chemotherapy patients.

**Seven-day services**

- **The oncology and endoscopy units did not provide seven-day services but had systems in place to respond to patients needs outside of service opening times.**
- The oncology service was open Monday to Friday. Patients were admitted between 8am and 2.30pm.
- There was a 24-hour telephone number for oncology patients to call out of hours. The surgical ward staff responded to any telephone calls out of working hours. Staff told us they had on occasions, administered treatment at the weekend upon a patient request.
- Consultants were contactable always to respond to concerns about patients that had attended for chemotherapy. Staff told us consultants were always responsive when required.
- The hospitals resident medical officer (RMO) was available 24-hours a day, seven days a week to support patients, hospital staff and care for patients.
- The endoscopy department was open between 8am and 5.30pm Monday to Friday. The service provided a Saturday service every sixth Saturday and intended to increase the frequency of Saturdays in the future.

**Health promotion**

- **Staff supported patients to manage their own health, care and well-being and to maximise their independence during and following treatment and as appropriate for individuals.**
- We saw health promotion information and materials on display in the units. Examples included; alcohol consumption, nutrition, mental wellbeing and use of scalp cooling.
- The oncology service provided a variety of leaflets on different aspects of cancer care, chemotherapy, managing symptoms and side effects of treatment.
- Chemotherapy patient were provided with a chemotherapy patient diary. This had useful information about treatment, side effects and how to manage them. There was a section to note the treatment completed, so patients could share with other professionals including their GP. The diary also contained useful numbers and instructions about what to do should they experience specific symptoms.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- **Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**
- During our last inspection in July 2016, we found there was an inconsistent approach to obtaining and documenting consent from patients being treated for chemotherapy. During this inspection, we were assured that improvements had been made in documenting consent. We reviewed ten chemotherapy patient records and nine had consistent paperwork that was completed correctly. One of the consent forms was not completed correctly as the patient had signed all sections indicating they both consented and did not consent to treatment. This was raised with the chemotherapy lead during the inspection and we were told that it would addressed.
- Consent for chemotherapy was completed by the consultant and then checked by nursing staff prior to any administration of medication. The service had a checklist in place, completed by nursing staff, to ensure that consent was obtained appropriately. We saw evidence that this was being used in all ten files we reviewed. However, the checklist did not effectively identify the consent form incorrectly completed in one patient record.
- The pre-chemotherapy assessment was used to discuss complications regarding treatment plans and the intent of treatment; this was evidenced in patients' notes and during patient discussions. Patients told us that both doctors and nurses went through consent and provided them with a detailed level of information.

Good

# Medical care

- Patients were provided with written information to help them understand treatment before it started. Patients attending the service for chemotherapy were advised of possible side effects of treatment during the pre-chemotherapy assessments and prior to attending for treatment. This ensured that patients had time to consider the impact of medications prior to agreeing to the treatment.
- The service had oversight of the level of compliance around consent to treatment for patients. The service completed a chemotherapy quarterly documentation audit. The November 2018 audit showed that 100% of files audited had evidence of patient information being provided and consent obtained.
- Three endoscopy patients we spoke to told us they were happy with the level of information they received about the procedure and all were happy with the consent process. We observed a patient being consented prior to a procedure. The consultant provided information to the patient, checked their understanding and clarified they were aware of the risks and that they agreed to go ahead with the procedure.
- Staff we spoke to in both oncology and endoscopy understood their roles and responsibilities under the Mental Health Act (MHA)1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff told us that it was rare that they received referrals for treatment for patients living with dementia or learning disabilities. Staff told us they would hold a meeting prior to treatment starting and put a detailed support plan in place.

## Are medical care services caring?

Good

Our rating of caring stayed the same. We rated it as good.

### Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- We spoke with seven patients during our inspection and all spoke highly of the care and compassion they were shown by all staff they encountered during their time at the hospital.
- Feedback from patients confirmed that staff treated them well and with kindness. One patient told us they were very happy with the service. Another patient told us they were anxious about the procedure but immediately put at ease by the staff who provided reassurance.
- We observed patients being dealt with efficiently within endoscopy. Patients were provided with private space whilst waiting for the procedure to take place. A patient in oncology told us it would be better if there was an area for their relatives to sit and wait. The new unit was designed with space for relatives to sit.
- We observed caring and positive interactions with patients during their consultations. Discussions and treatment took place in consultation and private rooms to ensure privacy. Nursing and medical staff used curtains around the bays in endoscopy and patients were covered up when sensitive procedures took place.
- Staff introduced themselves and took time to interact in a considerate and sensitive manner.
- Staff were friendly and helpful and responded sympathetically to queries in a timely and appropriate way. We observed positive interactions between oncology staff and patients. One patient we spoke to at the end of treatment commented that she will miss the staff when her treatment is over as they have made it a nicer experience than she expected.
- **Please see surgery report for details of the Friends and Family Test (FFT) and surveys.**

### Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff in both oncology and endoscopy understood the need for emotional support. We spoke with six patients and one relative who all felt that their emotional wellbeing was cared for. Oncology patients told us they received very good emotional support and felt they were provided with useful information and opportunities to ask questions.
- Patients were provided with a 'chemo patient diary'. The diary included information of support services and a page for patients to write down their concerns and

suggestions. The treatment plans for each treatment could be recorded in the diary and there was information about what to expect and possible risks to look out for.
- Patients were sent a self-assessment prior to treatment starting in oncology which asked about mental health and emotional support needs. This gave staff a better understanding of their patients' needs before starting treatment.

**Understanding and involvement of patients and those close to them**

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Oncology patients we spoke to all said they felt they had access to relevant information about their care and treatment and were involved in decisions about their care. One oncology patient told us they used the out of hours number and received the information they asked for.
- We observed positive interactions between staff, patients and concerned others. We observed staff explain procedures and what to expect in both oncology and endoscopy.
- Staff recognised when patients needed additional support to help them understand and ask relevant questions about their care and treatment. We observed staff checking in with particularly anxious patients awaiting endoscopy procedures and giving more support to unwell patients undergoing chemotherapy.
- In oncology we observed a hand drawn picture in a patient record which was used to illustrate a procedure to a patient pictorially.

## Are medical care services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

**Service delivery to meet the needs of local people**

- **The hospital planned and provided services in a way that met the needs of local people. People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.**
- During our last inspection in July 2016 we found that the endoscopy unit did not have a private area for booking patients in. There was very limited space for staff to conduct private telephone calls with patients. During this inspection, we observed that space remained limited, however patients were assessed and consented in a private room. The private room was used by staff to make telephone calls and conduct meetings, however during the inspection, we did not observe this impacting on patient care or service delivery.
- Clinical facilities and treatment areas in endoscopy were appropriate for the purpose they were used for. This included treatment rooms and recovery bays.
- The facilitates for chemotherapy patients did not always meet the patient's needs. The chemotherapy service used four patient rooms within Meadow ward as a temporary measure. The rooms were appropriate for the purpose they were used for. However, there was limited storage space for clinical equipment. However, the service was preparing to move into a purpose-built chemotherapy unit, designed to meet the patients' needs.
- The new chemotherapy unit was purpose built in response to the increasing demand for chemotherapy and was due to open in January 2019. The new unit had seven treatment spaces and a two-bedded room. The unit was built to allow all required clinical equipment to be all in one place and responsive to the patient need. The new unit design incorporated the views and recommendations of patients and staff.

**Meeting people's individual needs**

- **The service took account of patients' individual needs.**
- A robust process was in place to ensure patients' needs were being met. Patients individual needs were assessed during the pre-operative assessment. This included assessing for physical, mental health and social needs. Staff described how they had adjusted pathways for patients with complex needs such as mental health and learning disabilities.
- Staff knew how to access the translation services for patients who did not speak English. Where required, interpreters were booked for pre-assessments and before treatment.

- The hospital had disabled access throughout the site. Nursing staff told us that specific patient communication needs would be assessed before admission and were highlighted in the patient's medical records.
- Staff told us they very rarely cared for patients living with dementia, however, staff could describe how they would assess and support someone living with dementia. Data showed that 85.7% of staff in oncology and endoscopy had completed dementia training and we saw dementia awareness display boards around the hospital.
- A breast care specialist nurse based at Rivers Hospital supported breast cancer patients throughout the treatment journey. The breast care nurse supported the oncology clinics with consultants and communicated chemotherapy treatment plans with chemotherapy nurses following clinics. All breast cancer patients were provided with a breast cancer care resource pack.
- The service had pathways in place with local charities to support patients undergoing cancer treatment. For example, the chemotherapy service could refer patients into a local cancer charity and 'look good feel better' workshops. Both charities were set up to support patients and relatives during and after their treatment had finished.
- Patients in endoscopy were advised of possible side effects, complications, and what actions to take following discharge.

**Access and flow**

- **Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.**
- During our last inspection in July 2016, staff reported an increasing number of endoscopy procedure cancellations due to consultant unavailability. During this inspection, staff told us they rarely cancelled appointments. The service data showed that 480 (10% of total appointments offered) endoscopy appointments from January to December 2018 had been cancelled by patients. We saw that one clinic had been cancelled by the service due to both automated endoscope repressor (AER) machines not working. AER machines wash and decontaminate equipment used following an endoscopic procedure. Another clinic was cancelled due to unplanned absence of a consultant.
- The local clinical governance committee reviewed endoscopy cancellations and the service had an action plan in place regarding this. Managers told us that any patient considered urgent, or where there would be a delay in a diagnosis, would be routinely added to the next available list or added to another consultants list to minimise the delay, with an explanation to the patient.
- Rebooking compliance for cancelled procedures were monitored by staff. This required a firm date to be scheduled, based on patient need, within 28 days of the cancellation. Between January and December 2018, 100% of all endoscopy service cancelled procedures were rescheduled according to these standards.
- Endoscopy appointments were offered between three to six weeks from referral and within two weeks for urgent NHS referrals. Private patients were offered appointments within five days. The service operated a Monday to Friday service and offered a Saturday service every sixth week to enable flexibility. The service intended to increase the frequency of Saturday procedures.
- All patients we spoke to in endoscopy were very happy with the time it took to receive an appointment. One patient told us the time from referral to procedure was 'a quick turnaround' and they did not have to wait more than 2 weeks.
- The endoscopy service received a level 'A' for access and booking in their joint advisory group (JAG) accreditation in March 2018. Level A demonstrates excellent practice.
- The oncology service did not have a waiting list and the average wait from referral to treatment stating was less than seven days. The team worked flexibly to ensure patients were assessed and began treatment quickly.
- The oncology department offered appointments between 8am to 2.30pm from Monday to Friday. The chemotherapy service treated up to ten patients a day, three times a week. The service operated flexibly and, if necessary, would start a treatment at a weekend.
- An oncology pharmacist prepared individual chemotherapy medicine in advance to reduce patient waiting times when patients arrived.

**Learning from complaints and concerns**

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- There were posters and leaflets around the hospital with information about how to make a complaint. Patients

were advised about the complaints process at the pre-assessment stage. Patients we spoke to said they did not have a reason to make a complaint but knew how to do this if they needed to.
- Staff told us that if a patient raised a concern, they would listen to the feedback and try to resolve the issue. If they were unable to do so, it would be escalated to the chemotherapy and endoscopy lead or person in charge.
- The senior management team had oversight of all complaints. All clinical patient complaints were discussed at the head of department meetings and clinical governance committee meetings. Complaints were then fed back to departments and there was evidence of them being discussed at ward meetings. The chemotherapy and endoscopy service received feedback from the respective leads and at ward meetings.
- No formal complaints were received by the endoscopy or oncology service from July to December 2018.
- Staff in the chemotherapy service described how they dealt with a recent informal complaint about treatment being administered in a shared room with another patient. Staff quickly dealt with the complaint and used the feedback when planning the new purpose-built unit. The new unit was open plan and fitted with adjustable divides and a separate room that can be used if patients required more privacy.

## Are medical care services well-led?

Good

Our rating of well-led improved. We rated it as good.

### Leadership

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**
- Nurse leads in both oncology and endoscopy told us senior management were supportive and visible. The medical care service was led by the matron and both endoscopy and chemotherapy services had a lead nurse and a senior sister.
- Nursing staff in both departments said that leaders were visible and approachable and felt that they could express any concerns to them and they would be listened to. All staff we spoke to talked about the 'ten at ten' meeting. This was a meeting during which senior managers talked about a variety of current issues such as staffing and incidents. Staff told us that the 'ten at ten' meetings made the senior leadership team more visible. Staff were provided with feedback from these meetings.
- Staff talked positively about the matron. Staff told us that if they had a concern they felt comfortable talking to the matron and felt confident that concerns would be acted on.
- The May 2018 staff survey demonstrated a reduction in staff opinion of the senior management team. However, the senior management team had followed this up with staff engagement events in August where 80 staff members attended and an improvement plan was put in place. Staff spoke positively about the senior management team during the inspection; they told us they could approach management if they had a concern.

### Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.**
- At our last inspection in July 2016 we found that medical care services did not have a well-defined vision and strategy. Although we found that staff understood the provider's broader strategy and development plans, we did not find evidence of a specific medical services strategy. However, we found evidence that medical services formed part of a wider commercial strategy and business plan for the hospital. For example, the commercial strategy outlined plans for development of cancer services. This included the intention to build a purpose build chemotherapy unit that the service was in the process of moving into during the inspection.
- Patients who required radiotherapy had to go to another hospital for treatment. The hospital business plan for 2018/19 set out its vision to build a purpose build radiotherapy unit. The hospital was in discussions with a third party with regards to providing radiotherapy services on-site in the future.
- Staff could describe the plans for medical services and could tell us the areas for improvement required. Staff told us they were included in service developments,

such as the design of the new chemotherapy unit. For example, the chemotherapy nurses requested mobile cannulation and chemotherapy trolleys in the new unit to improve safety when administering treatment.
- The service also gathered patient feedback and ideas to ensure that the unit was patient focussed. For example, patients were asked about the environment and decoration; as a result, the chosen colour scheme was a result of patient feedback.
- Staff could talk generally about the hospital values, described as the 'Ramsey Way'. We observed notice boards around the hospital with information about the values and principles of the Ramsey way.

**Culture**

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff at all levels and in clinical and non-clinical positions told us that they felt valued as part of the team and felt that their contribution mattered. A health care assistant and cleaner told us how much they liked working at the hospital. The matron spoke with pride about the work and care all the staff delivered daily.
- There was a culture of openness and transparency. Staff at all levels spoke of identifying areas to improve the patient experience. The hospital had recently rolled out a 'speaking up for safety' campaign. Training workshops were provided for staff aimed at improving openness, communication and assertiveness around patient safety.
- During our previous inspection in July 2016, we found that some staff did not feel confident in raising concerns about staffing levels to senior managers. During this inspection, all staff we spoke to felt confident in raising a concern. Two staff members told us they had discussed staffing levels with senior management and felt their concerns were listened to and taken on board.
- Managers had processes in place to improve the culture in the hospital, following the outcomes of the staff survey completed in March 2018. Staff were provided with opportunities to feedback their concerns and formulate an action plan to improve the culture. Staff were aware of the improvements made, for example, the ten at ten meetings and staff forums.

**Governance**

- **The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- During our previous inspection, in July 2016 we found:
  - The illegibility of medical records in the chemotherapy service had not been recognised by the service prior to the inspection.
  - The lack of documented consent in all patients' chemotherapy records had not been recognised as a risk prior to the inspection. The hospital took actions to implement new systems to address this after the inspection.
  - Whilst there was a governance system in place, there was not a robust system for learning from all incidents and complaints to improve services.
- During this inspection, we found evidence that the hospital had acted upon these risks, demonstrating a system for learning was in place. For example, the service had put in place a records checklist to ensure all relevant information and documentation was in place. We observed the checklist in all ten of the records we reviewed. There was also a quarterly documentation audit to review the quality of records, therefore we were assured that the risks had been acknowledged and acted on.
- There was a systematic programme of clinical and internal audit to monitor quality and operational processes. However, the programme was not specific to oncology or endoscopy. There were however specific measures for endoscopic decontamination. The chemotherapy unit completed their own quarterly documentation audit.
- The hospital had a comprehensive audit and risk management structure which ensured the service had a transparent approach to the management of risk and the assurance of safety. For example, audits included infection control, hand hygiene, medicines management, patient records, endoscopy decontamination and isolation. Compliance ranged from 91% in the operational theatre audit to 100% in the central venous catheter care bundle audit.
- The service leads attended a number of meetings and committees. Discussions at these meetings were discussed with staff locally. For details of governance structure and process, please see the surgery report.

Good

# Medical care

**Managing risks, issues and performance**

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- During our previous inspection in July 2016, we found the risk register for medical services was not updated regularly. It did not identify risks to the delivery of safe care and treatment that was found during the inspection. During this inspection, we were assured that the risk register was updated regularly and had identified risks related to oncology and endoscopy. For example, risk of harm due to poor handling and safe disposal of cytotoxic drugs was on the risk register.
- The endoscopy and oncology service did not have their own risk register; specific risks for the service was included in the ward risk register. Specific risks were incorporated into the hospital wide risk register. For example, carpet in patient rooms and ineffective prevention, infection control symptoms. It was discussed at the medical advisory committee (MAC) and head of department meetings. There was evidence that wards also discussed risks on the register at their meetings.
- There was evidence that potential risks were considered when planning services. For example, the new purpose build chemotherapy unit design considered risks of management of cytotoxic waste, infection prevention and control and patient safety. Whilst it was not on the risk register, the endoscopy unit had a robust process in place to managing incidents such as the endoscopy washer (AER) machines being out of use. The service had a risk assessment and contingency plan outlined in the endoscopy operation policy.
- Staff were aware of the main risks within the endoscopy and chemotherapy units. For example, chemotherapy staff told us that their main risks were extravasation, spillage of cytotoxic waste and the treatment being administered. Staff could describe how they would manage these risks and knew what policies to refer to.

**Managing information**

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Local leaders had a holistic understanding of performance. Information was used to measure improvements. There were clear and robust service performance measures in place, which were monitored at governance meetings.
- The service had a wide range of information available to them to enable service leads to assess and understand performance. This included data in relation to quality, safety, patient experience, human resources, operational performance and finances. However, due to the size of the oncology department, information was often incorporated into the wider hospital. It was therefore difficult to assess oncology performance.
- The hospital produced a monthly integrated audit report which listed their performance, however oncology services were not specifically audited. We observed endoscopy specific audits such as decontamination procedure audits. Hospital targets were set in relation to these indicators and performance was rated using the traffic light, RAG (red, amber, or green) rating system. This allowed managers to assess their performance at a glance and identify those areas which required further improvement or investigation.

**Engagement**

- **The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services.**
- Please see the surgery report for detail of hospital wide engagement.
- The hospital gathered patients' views and experiences to shape and improve the services and culture. For example, service users and staff were involved in the design of the new chemotherapy unit. The commercial strategy plan identified an action to improve the friends and family response rate to 40% by year end (April 2019). There were processes in place for both endoscopy and oncology staff to gain feedback from patients.

**Learning, continuous improvement and innovation**

- **The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.**
- The medical service took on board feedback following the previous inspection in July 2016 to improve the patient experience for oncology patients. For example, the service designed a purpose-built chemotherapy

unit, so that all services offered could be delivered from a designated unit. This includes assessment, treatment and bays for patients requiring to be admitted. The unit was designed with input from patients and staff. The unit was designed so all equipment is easily accessible to staff including emergency medicines and treatment trolleys. Patients will have more choice about how they experience the service, for example, they can interact with other patients or chose a more private space. Divides between patients' bays were movable to enable privacy or interaction.

- Whilst the new unit was being built, the department managed to continue to provide a quality service in a temporary setting. The service continued to put measures in place to improve documentation, consent and the environment following feedback from our previous inspection in July 2016. For example, all chemotherapy patients undergoing treatment, were treated in non-carpeted rooms; a requirement following the previous inspection.
- The endoscopy service maintained the joint advisory group accreditation. They also implemented measures to ensure files were locked away in draws behind the nurses' station; as a result of feedback from the inspection in July 2016.

Good

# Surgery

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

## Are surgery services safe?

Good

Our rating of safe stayed the same.We rated it as **good.**

**Mandatory training**

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The service had an up to date mandatory training policy, this was available to all staff through the intranet. Mandatory training was provided by either e-learning or face to face sessions. Topics included immediate life support, basic life support, emergency fire safety, infection control, information security, safeguarding children and adults, dementia, sepsis and PREVENT. PREVENT training is part of the government's counter-terrorism strategy.
- The service maintained a mandatory training tracker. All completed training was RAG (red, amber and green) rated. Staff were informed by email to book onto mandatory training. Managers ensured that mandatory training was booked onto duty rotas.
- Mandatory training figures were provided for the hospital and not individual departments. The compliance target for mandatory training was 95%. Not all staff had undergone all mandatory training, overall compliance was 85.4%. For example, compliance for basic life support was 72.4%, infection control was 76.4%, dementia training 67% and immediate life support (ILS) was 38.7%. Managers told us that ILS training was provided by an external company and that a training session had been cancelled by the company. This was being re-booked. However, 92.7% of staff had received training for sepsis and aseptic non-touch technique (ANTT). ANTT and sepsis training had been updated to include all clinical staff, not just nursing staff. The training record was being amended to reflect this change. Following our inspection, we requested compliance information for surgery and actions being taken to ensure compliance. Minutes from ward and departmental meetings indicated that there was limited discussion about mandatory training. Staff told us that e-learning was easy to access and time was provided for this. There was an induction programme for all new staff and staff who had attended this programme felt it met their needs.
- The organisation that supplied registered medical officers (RMOs) to the hospital ensured they maintained 100% compliance with mandatory training. All RMOs were trained in Advanced Life Support (ALS).
- Consultants working for the hospital under practising privileges, did not receive mandatory training from the service. Training was provided from their substantive place of employment and the hospital kept a record of their completed training. Practising privileges is an established process within independent healthcare where a medical practitioner is granted permission to work in an independent hospital in the range of services they are competent to perform.

**Safeguarding**

- **Staff understood how to protect patients from avoidable harm and abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.

- The safeguarding adults' leadership had recently changed. Previously the role was combined with the safeguarding children lead role. Following a review of the portfolio, it was agreed that the head of clinical services (Matron) adopted the role for adults. The lead roles and responsibilities included the attendance at area meetings, providing training and offering support and guidance.
- **Please see the Children and Young People report for details of children's safeguarding.**
- The service had processes in place to protect patients from avoidable harm and abuse. There were safeguarding adults and children's policies in place. Policies were accessible to all staff through the intranet. Policies were in date and clearly identified all types of abuse including child sexual exploitation (CSE), female genital mutilation (FGM), forced marriage and Prevent.
- Prevent is part of the government's anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. Prevent training formed part of the wider safeguarding agenda and encouraged staff to view a patient's vulnerability as they would any other safeguarding issue.
- Staff had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. Nursing staff could describe and demonstrate how they would respond to a safeguarding concern, using real examples of concerns they had effectively escalated and referred to local safeguarding services.
- Staff spoken with had a good awareness of female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Staff confirmed FGM was included in their induction training. Staff understood their responsibilities regarding FGM and described the actions they would take if they had any safeguarding concerns.
- The hospital established the level of safeguarding training needed for staff based on their job role and type of contact they had with patients. Staff were required to complete safeguarding level one and two for adults and children as part of their mandatory training. Records showed that most staff had completed level two safeguarding for both adults and children. Staff described and understood the processes they would take to ensure the immediate safety of patients. The ward managers, matron and clinical heads of department were trained to level three. All staff working in theatre and recovery were trained to level three.
- Managers monitored compliance with safeguarding training monthly. The hospital had a local safeguarding register to log all concerns, which were reviewed by the head of clinical services. A decision would be made to contact the appropriate community safeguarding team where appropriate. Staff confirmed they had a good relationship with external agencies that they could ask for advice regarding safeguarding concerns.

**Cleanliness, infection control and hygiene**

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.** They used control measures to prevent the spread of infection.
- All areas were visibly clean and tidy. The site was well maintained. Theatre areas were clean and the sterile store was well organised. There were systems in place for the decontamination of used surgical items. These were sent off site for decontamination in accordance with national guidance (CFPP 01-01).
- We were told that there was a robust programme for maintaining the site. This included a refurbishment programme for decorating, estates and maintenance work and gardening.
- The hospital had an infection prevention control (IPC) lead who offered specialist advice and support on infection prevention control issues. The service had an infection control link nurse to support good networking and clinical practice amongst all staff. A corporate infection control lead and a microbiologist were also available for advice and support.
- Data provided showed there were no reported cases of methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile, Methicillin-susceptible Staphylococcus Aureus (MSSA), a type of bacteria (germ) which lives harmlessly on the skin and in the nose or E. Coli from July 2017 to June 2018. The hospital reported that there was one incident of C.Diff, however this was attributed to an external source. Identified infections were reported using the hospital's electronic incident report and management system.
- There were systems in place to prevent and protect people from the risk of healthcare associated infection.

We saw this was in line with current legislation from the National Institute for Health and Care Excellence (NICE) Quality Standard 61: 'Infection Prevention and Control' (2014). All patients admitted for surgery were screened for MRSA, CPE (carbapenemase producing enterobacteriaceae) and C-diff.

- All staff seen adhered to the arms bare below the elbow policy. Staff had access to appropriate personal protective equipment (PPE) such as disposable aprons and gloves. Hand gel was widely available and easily accessible. All hand wash dispensers that we checked were full and in working order. Clinical hand basins were provided in utility areas but not in patient's rooms. This meant that at the point of care, staff were washing their hands in patient's private bathrooms. National guidance recommends having dedicated clinical sinks within each en-suite room. Department of Health guidelines (2013) HBN00-09 state that "En-suite single bed rooms should have a general facility in addition to the clinical wash-basin in the patient's room. This had been identified at the previous inspection in 2017 and was not on the corporate risk register. During this inspection we saw that staff used gloves and hand gel frequently.
- Waste management was handled appropriately with separate colour coded arrangements for general and clinical waste. We found all sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste. We saw that a used suction cannister was left in theatre attached to the anaesthetic machine. However, we immediately raised this with staff and it was replaced with a clean unit.
- The hospital stored hazardous substances appropriately and in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health. We saw evidence across the surgical service of up to date COSHH risk assessments to support staff's exposure to hazardous substances.
- Department cleaning schedules were in place. Internal audits of cleanliness are undertaken weekly. Regular audits were undertaken by the housekeeping manager and head of department. The latest audit completed in June 2018 for all departments demonstrated a compliance of 97%. Equipment cleaning schedules were also undertaken. "I am clean" stickers were utilised throughout the hospital, however, whilst equipment looked clean not all equipment had an "I am clean sticker".
- The service had removed carpets from the ward corridors and patient rooms to improve the appearance and cleanliness of the area.
- There was an infection prevention and control (IPC) annual audit programme. Monthly infection control audits included adherence to hand hygiene, urinary catheter and vascular access device protocols. The monthly hand hygiene observational audits between July and September 2018 showed an overall compliance rate of 80-95%. We saw that audit results were discussed at ward meetings and a re-audit was to take place.
- A hospital wide hand hygiene audit was completed in July 2018; 95% of the observations were complaint with good hand hygiene practice. The audit identified issues with adherence to the uniform policy and non-compliance with jewellery. Findings were shared with the infection control committee and communicated to staff.
- There was an infection prevention and control committee (IPC) which comprised of a consultant microbiologist, infection control lead; matron; pharmacy link and theatre manager. There were also links from all departments including x –ray, theatre and house-keeping. Meetings were held quarterly and provided the hospital with infection prevention advice and guidance in conjunction with corporate infection prevention and control policies and procedures and national guidance. A consultant microbiologist chaired the IPC meetings and was available for any queries.
- Managers held monthly infection and prevention control committee and hand hygiene meetings. We saw that there was a standard agenda which included feedback from internal meetings, for example head of departments (HODs), health and safety and clinical governance meetings. Audit, action plans following audit, mandatory alert organisms, surgical site infections, complaints about infections, incidents and training were discussed in the minutes of these meetings.
- Infection prevention and control updates were reported to the clinical governance team in a clinical governance report monthly. Root cause analysis (RCA) was carried out in all cases, and included in the clinical governance

report. Quarterly infection prevention and control reports were also produced by the organisation for commissioners and the board, with exception reports as required.

- A central alerting system (CAS) alert was sent to all heads of department informing them of new policies and any updates. The IPC lead renewed all updates and actions if necessary.
- An antimicrobial policy was in place with antimicrobial prescribing guidance for all staff administering and prescribing antimicrobials. An antimicrobial stewardship electronic application "app" was used for staff to access to updated information.
- The service had a service level agreement with the local NHS trust in place to access a diagnostic microbiology laboratory.
- Patients were given an admission booklet with pre-operative washing and shaving instructions to reduce the risk of surgical site infections. We saw this information shared with a patient in the pre-assessment unit. Patients were provided with information about who to contact if they had any concerns relating to IPC. When patients were discharged they were given hand hygiene and wound care leaflets with telephone numbers advising them to contact the ward if they had any infection control concerns. If a patient had an infection this information was electronically relayed to the GP service with the discharge information.
- Surgical site infections for replacement hips or knees, were reported in line with national guidance. For the period July 2017 to June 2018 there had been three surgical site infections for primary hip replacements and two surgical site infections for primary knee replacements. Each incident had been reviewed by the relevant admitting consultant and treatment provided as required. No trends were identified.

**Environment and equipment**

- **The service had suitable premises and systems in place to ensure equipment was well looked after.**
- There was sufficient equipment to maintain safe and effective care such as blood pressure and temperature monitors, commodes and bedpans. Staff told us that they could obtain equipment easily if it was required. A hoist was available with a selection of disposable single use slings and was situated within the ward area. We saw that all electrical equipment had been electronically tested and was in a good state of repair.
- The hospital had an equipment replacement plan. This included the replacement of expensive imaging equipment as well as smaller items. We were told that they were in the process of replacing the MRI scanner, although were waiting for the confirmation of additional contracts prior to purchasing the equipment to ensure that the most suitable items were purchased.
- Equipment was predominantly maintained by the manufacturer through a service level agreement. The senior management team (SMT) held a log which detailed the dates of equipment replacement and servicing to ensure that all equipment was safe to use.
- The environment was clean and all areas seen were free from extraneous items. Storage areas and clinical rooms were clean, tidy and well organised. Cleaning schedules were in place and were audited weekly.
- Patient bedrooms in ward areas were well maintained and had an appropriate nurse call system. All bedrooms were en-suite. The flooring in patient rooms was non-slip.
- Not all the patient rooms had piped oxygen and suction. Additional oxygen cylinders were stored in an upright position in a designated area on the ward. These were clean, complete and in full working order. Additional suction equipment was available for use as necessary. Staff told us that patients who required additional observation and monitoring would be in rooms close to the nurse's station and which had piped oxygen and suction.
- Resuscitation equipment containing medicines and equipment required in an emergency, were accessible both on the ward and in the operating theatres. Resuscitation trolleys were secured with tamper proof seals. Resuscitation trolleys were checked daily. We saw that daily checks had been carried out and that this was audited monthly.
- Operating theatres were compliant with Health Technical Memorandum 03-01 Specialist ventilation for healthcare premises. This meant there was an adequate number of air changes in theatres per hour, which reduced the risk of infection to patients.
- The service had five laminar flow, ultra clean ventilation theatres. The air handling units in two theatres, the recovery area and endoscopy suite had been upgraded over the last 12 months. There were further plans to upgrade the air handling units in two other theatres.

- There were effective arrangements in place for the appropriate decontamination of instruments and other reusable medical equipment. This was in line with the Health Technical Memorandum (HTM) 01-01 (England).
- There were effective systems in place for the tracking and tracing of specific implants and equipment. We saw that identification numbers were clearly documented in the patient's records.
- The 2018 Patient Led Assessment of the Care Environment (PLACE) assessment for condition, appearance and maintenance showed that the hospital had scored 96. % which was higher than the national average of 94.%.

**Assessing and responding to patient risk**

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- The surgical service had an admission policy which set out guidelines for the safe admission of patients. Patients attended a nurse led pre-assessment. During the assessment all necessary tests were undertaken.
- Patients identified as a higher risk for anaesthesia were further assessed by an anaesthetist before being accepted for surgery. The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk.
- The hospital operated a 24 hour on-call rota for all clinical areas and senior managers.
- Theatre staff attended a morning safety huddle to ensure all patient needs and risks were identified. We saw that pre-operative checklists were fully completed; staffing arrangements and allocation of duties were understood.
- The theatre team followed the National Patient Safety Agency 'Five steps to safer surgery' as part of the World Health Organisation (WHO) surgical safety checklist. We observed staff using this efficiently, completing all elements in the checklist.
- Managers audited compliance with the WHO surgical safety checklist. Results from August to September 2018, showed 100% compliance with the completion of the paper forms. There was 80% compliance with a team debrief occurring and with all theatre members present. However, this represented one out of five checklists observed.
- National Safety Standards for Invasive Procedures (NatSSIPs) were not available in the theatre department. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). Staff we spoke with in the theatre department were not aware of national and local safety standards.
- A monthly patient journey audit was completed within surgery, where the content of the patient records was reviewed. This was based on 43 key questions and the areas reviewed included; venous thromboembolism (VTE) assessments, the patient's height, weight, body mass index (BMI) score and fluid balance charts. For example, the July to September 2018 based on 30 records was RAG (red, amber, green) rated and showed an overall score of 91% (cool amber). Scores ranged from 0% to 100%. For example; the service scored 7% for the calculation of patients' weight and target urine output been recorded correctly in millilitres per hour. Actions to improve compliance included teaching sessions, further audits and raising awareness at staff meetings.
- Risk assessments for VTE were completed during the preoperative assessment by nursing staff. We found that risk assessments had been carried out on a patient's admission to the hospital which was in line with NICE guideline NG89, 2018. We looked at seven records and found they all contained completed VTE assessments. From July 2017 to June 2018, 99-100% of adult inpatients were risk assessed for VTE.
- There was a deteriorating patient policy in place which included guidance and treatment pathways for the national early warning score 2 (NEWS 2). NEWS 2 was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Staff used the NEWS 2 to record routine physiological observations, such as blood pressure, temperature, and heart rate. The NEWS 2 prompted staff to take further action, such as increasing the frequency of monitoring vital signs and requesting a review from the registered medical officer (RMO). We looked at seven records and saw that they had been calculated accurately, none of these had required escalation. Staff described the actions they would take if a patient deteriorated, this included increasing observations and informing the RMO and consultant. Compliance with NEWS 2 was not included on the patient journey audit.
- The deteriorating patient policy included guidance and treatment pathways for sepsis such as sepsis six

guidance. Sepsis six is the name given to a bundle of medical interventions designed to reduce the death rates in patients with sepsis. We were told that patients suspected of having sepsis would be transferred to the local NHS hospital for ongoing monitoring and treatment. We noted that compliance with sepsis screening was not included on the patient journey audit.

- The hospital had a 'massive blood loss' protocol and there were appropriate arrangements for ensuring blood required for elective surgery was available when required, and for obtaining blood in an emergency. There was access to the minimum requirement of two units of emergency supplies of O Rhesus negative blood. Nursing staff were aware of where the emergency blood was stored and how to obtain it, if required. The blood fridge temperature and stock was checked and recorded daily. The hospital had an SLA in place with the local NHS trust for the supply of blood.
- If a patient's health deteriorated, staff were supported by a resident medical officer (RMO). The RMO was a registrar level doctor who was on duty 24 hours a day and was available on site to attend any emergencies. The hospital had a transfer agreement in place with the local acute trust should a patient require a higher level of care or urgent diagnostics. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care. A service level agreement (SLA) was in place with the ambulance service for the safe transfer of patients to the local NHS trust. From January to June 2018 there had been 14 unplanned transfers to other hospitals.
- The practising privileges agreement required surgeons to be contactable when they had patients in the hospital and if needed to be able to attend the hospital within 30 minutes in the event of patient deterioration.

**Nursing and support staffing**

- **The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service had systems in place to ensure that there was always a designated senior person in charge in each department. Managers used an acuity tool to ensure that they met appropriate safe staffing levels. Staffing rotas on the ward were planned four weeks in advance and skill mix and dependency were reviewed in advance on a weekly and daily basis to assess the workload. A software application (app) was used by staff to request shifts. Staff told us that this worked well and that staffing levels were adequate.
- Managers had introduced a template to monitor staffing levels and patient numbers at intervals throughout the day. Managers could reflect on this to demonstrate that staffing levels met the capacity and needs of patients. Managers offered staff any time off in lieu, annual leave or would ask additional staff to work as necessary. Ward managers would work clinically as necessary. We reviewed staffing rotas and saw that sufficient nursing staff were on duty.
- Theatre staffing rotas were completed one week in advance. Managers told us that this was because of numerous changes made in response to patient activity. Operating theatres and recovery area staffing was compliant with The Association for Perioperative Practice (AfPP) guidelines. Additional staff were added for longer operating lists or those that required a surgical first assistant. Surgical first assistants are registered healthcare professionals who provide continuous, competent, and dedicated assistance under the direct supervision of the operating surgeon throughout the procedure, whilst not performing any form of surgical intervention. Managers told us that they would work clinically to cover shifts if necessary.
- From May 2018 to July 2018, 17 registered nursing shifts were filled by regular bank staff and six shifts were filled by health care assistants on the ward. No agency staff were used on the ward during this time. Theatres had 213 registered nurse shifts filled by regular bank staff, three shifts were filled by regular agency staff. Bank operating department practitioners (ODPs) and health care assistants covered 81 shifts. No agency staff were used. During the inspection, we observed a good skill mix across the surgical service with appropriate levels of nursing staff to meet patient needs. Between May 2018 and July 2018 no shifts were unfilled.
- The service was staffed with contracted, bank and agency staff. Bank nurses were usually regular staff who were familiar with the hospital. Staff were recruited from specific agencies with, which the hospital had a preferred provider arrangement. This ensured that these staff met key requirements such as having completed mandatory training. New agency staff received an orientation of the service. This included access to and the location of emergency equipment and fire exits.

- On call arrangements were in place in the event of a patient requiring an urgent return to theatre. Staff told us that they were rarely called out.
- Managers of all departments met at a daily safety meeting where any staffing concerns for the day and the current week were discussed and plans were made to ensure safe staffing levels were maintained to meet the individual needs of patients.
- Inpatient nurses and health care assistants employed by the hospital
  - Nursing staff – 41.8 whole time equivalents (WTE).
  - Health Care assistants (HCAs) – 14.3 WTE.
  - Theatre - nursing staff -21.78 WTE.
  - Theatre – ODP registered and HCAs – 19.84.
- From August 2017 to June 2018 staff sickness levels for inpatient nursing staff and theatre was between 1% and 8.5%. Health care assistant sickness inpatient staff varied between 0% and 10.9%. Sickness levels for theatre nursing staff varied between 0.5% to 15.6%. ODP and HCA sickness rates varied between 0.5% to 7.6%.
- Staff sickness rates were also monitored corporately and by the local team. Data showed that sickness rates at Rivers Hospital was in line with and better than a number of other Ramsay Hospitals.
- From August 2017 to July 2018 staff turnover was 0.3% which was 0.6% lower than the previous year.
- Staff turnover rates were monitored centrally by the corporate team as well as locally by the senior leadership team. Data showed that the turnover rates for the hospital was 4% for clinical staff and 11% for non-clinical staff. This was in line with other Ramsay Hospitals and in the better half of their peers. Theatre managers were actively recruiting all grades of staff and planned to interview soon.

**Medical staffing**

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

- Patient care was consultant led. There were 248 consultants working at the hospital under practising privileges. In order to obtain the right to work at the hospital, a consultant would make a formal application which was reviewed by the senior management team, medical advisory committee and the corporate team. The consultant's qualifications and competence was reviewed in line with a description of the services they were planning to provide to ensure that the hospital was the correct environment and that they could access the necessary equipment and support.
- The hospital practising privilege agreement required that the admitting consultant took lead responsibility for patients during their hospital stay and after discharge. All consultants were expected to confirm at least one colleague as cover in their absence. Managers had access to contact numbers for all consultants. The lead consultant was responsible for referring patients to, and gaining input from, other specialists while they are resident in the hospital. Service level agreements were in place for support from other specialists to ensure the safe care of patients.
- Anaesthetists remained responsible for the ongoing care of patients who had an anaesthetic. The anaesthetic group from the local NHS trust provided a weekly rota to cover theatres and support pre-assessment. An on-call rota was also provided. Anaesthetists who undertook the patient procedure were responsible for their patient within the first 24 hours following surgery. Should a patient have required an anaesthetic review following this period this was done through the on-call rota.

- Consultants had agreed with the hospital management to attend the hospital to review surgical patients who had medical complications or an exacerbation of pre-existing conditions following surgery. Physicians offered advice on care or treatment or recommended transfer of care to the NHS trust when a higher level of care was required.
- Radiologists supported the hospital out of hours and at weekends and attended the hospital if the consultant in charge requested their support. Radiologists could review any imaging remotely.
- The service had access to a consultant microbiologist who supported the hospital and the consultants with advice and guidance.

- The hospital had a rota to ensure that a resident medical officer (RMOs) was on call to provided emergency cover and medical advice 24 hours a day, seven days a week. The RMOs worked a week on duty every four weeks and stayed within the hospital during this time. Rotas were arranged so that there was one RMO always available in line with national guidance. RMOs were provided by an agency and the hospital had

robust systems in place regarding the competency of RMOs working in the service. Should an RMO become ill or feel tired during that week they could request cover for their shift during that week through the agency.

- The RMO was supplied by an agency who provided their mandatory training which had to be completed before they could work at the hospital. All RMO's had advanced life support (ALS) and advanced paediatric life support (APLS) or European paediatric advanced life support (EPL)S training.
- The RMO provided cover for all the services on the hospital site, including surgery, outpatients, physiotherapy and imaging. The RMO provided support to the clinical team in the event of an emergency as well as carrying out routine jobs such as prescribing medication and taking blood from patients.
- The RMO liaised with consultants about patient care and treatment when they were not in the hospital. The RMO would contact the consultant, an anaesthetist and the director of clinical services with any concerns and reported having a good working relationship with the hospital pharmacist.
- The RMO told us they had sufficient time to handover to the new RMO coming on duty, nursing staff and consultants. Nursing staff and the RMO told us consultants working in the hospital were supportive and responsive whenever they contacted them for advice.
- The RMO and staff we spoke with confirmed that consultants were available and reviewed patients when requested to do so. We saw evidence of this in the patient notes. We saw consultant contact numbers were available for staff.

**Records**

- **Staff kept detailed records of patients' care and treatment**. Records were clear, up-to-date and easily available to all staff providing care.
- The hospital used a paper based system for recording patient care and treatment. Patients' medical records were stored securely in locked cupboards and behind a locked door. All areas storing patient notes was secured by either keypad or fob access.
- During our last inspection in June 2016, assessments and observations of care and treatment were not all accurately and routinely documented and not all records were legible. We reviewed nine sets of patient records and found these to be in good order. Medical and nursing records were legible, integrated and contained information of the patient's journey through the hospital including pre-operative assessments, investigations, pathology results and treatment provided. There were separate pathways for each speciality or procedure. Most entries were signed and dated.
- During our last inspection in June 2016, we found that not all case notes included fluid balance charts when they were required to do so. Following the June 2016 inspection, mandatory staff training had commenced regarding the accurate maintenance and recording of patient's fluid balance. During this inspection, we found fluid balance charts were included in five out of nine records. We found inconsistencies in the prescribing and recording of intravenous fluids. For example, we saw that in theatre records intravenous fluids were prescribed as crystalloid or colloid. Batch numbers and dates of expiry were not recorded in all cases. This meant that clear auditing processes could not be followed to ensure that the correct fluid was being given to the patient or to identify fluids if there were any manufacturing or recall concerns. The hospital intravenous fluid policy did not refer to the recording of fluids on the fluid balance chart. We informed ward managers of these concerns during our inspection. Following our inspection, we requested details of the processes in place to track IV fluids if an incident occurred. Managers provided the Ramsay policy for reporting adverse events for medical devices, but did not supply details of how the batches were tracked.
- Patient records had stickers which identified the equipment used and the serial codes used for implants, for example replacement hip joints and scopes used in endoscopy. This enabled patients to be tracked and equipment identified if a problem became apparent later.
- There were processes in place when patients moved between teams, services and organisation, which included referral, discharge, transfer and transition. We saw all the information needed for their ongoing care was shared appropriately
- Nursing staff sent discharge summary letters to GPs following a patient's discharge. This gave details of the

operation performed and any medication required as a continuation of their care. Consultant and RMO contact details were provided to GPs so they could contact them for further advice if required.
- We saw that staff logged off computer screens when they were not in use. This meant that information security was maintained.
- All external communication was sent by secure email and the service did not accept faxes from external sources. The service was compliant with general data protection regulation GDPR guidance on consent to communication and the storage of patient information. Staff verified patient identification with any requests for information or patients notes. If images and reports were sent to patients, digital versatile discs (DVD's) were encrypted and password protected. Imaging and reports were sent through a secure image exchange portal.

**Medicines**

- **The service followed best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time.
- The hospital had a medicines' management policy which was in date and due for review in 2021. However, following our inspection we requested additional information and were provided with a copy of the previous policy. Therefore, we could not be assured the most up to date policy was being used.
- Pharmacy services were available on-site Monday to Friday 9.am to 8.30pm, Saturday 9 am to 2pm. An out of hours on-call service was available. The service had a pharmacist who visited the ward Monday Friday. The pharmacist provided advice and guidance to the RMO, checked prescriptions and stock levels.
- Medicines were supplied by the on-site hospital pharmacy. Staff ordered, dispensed and disposed of medicines safely and securely. Arrangements were in place to facilitate medicine supplies out of hours. This meant that staff could access medicine supplies throughout the day and out of hours.
- Medicines were stored securely in locked cabinets and fridges within locked clinical treatment rooms. Only relevant clinical staff could access them. Medicines used for internal use and external use were stored separately. Medicine storage rooms had suitable preparation facilities for all types of medicines for example; controlled medicines and antibiotics. Controlled medicines (CDs) are medicines such as morphine which are controlled under the misuse of medicines legislation. We saw all CDs were checked daily by two nurses in accordance with guidance. The CD audit for September 2018, demonstrated 97% compliance with procedures.
- All intravenous fluids were stored appropriately and accessible to relevant staff. We saw that in theatre were drawn up as they were needed. The pharmacy team undertook monthly and quarterly audits with any identified issues fed back directly to the wards for learning and improvement.
- We saw that fridge and ambient room temperatures were checked daily and were maintained within safe limits in all of the areas we looked at. Staff described actions to take if these were out of the safe range.
- Prescription charts were fully completed, we reviewed seven charts and all were signed and dated. Prescription charts contained information including patient allergies and weight. Time specific medication was given on time and where appropriate, antibiotics had been reviewed. The charts did not include a venous thromboembolism (VTE) assessment, however, this was included in patient's records. If patients were self-administering medication this was identified on the prescription chart.
- There were policies and processes in place for patients who self-administered medicines. Patients were not able to self-administer analgesia or controlled medicines. Medical, nursing or pharmacy staff assessed patients to ensure they were competent to self-administer medication and asked patients to sign a resident self-medication form. Patients signed to agree to lock their medicines in a wall mounted cupboard in their bedroom. Staff told us that they checked with the patient that they had taken their medication and signed for this on the prescription chart. Information provided by managers stated that this process would only be applicable to patients who were independently mobile. During our inspection, a patient was self-medicating but was unable to get out of bed unaided and could not access their medication. No doses of medication had been missed but we were not assured that all patients were able to safely manage their own medicines. We raised this with managers during our inspection who provided copies of the assessment checks, and information provided to patients.

- A medicines' audit schedule was in place. The service audited the use of CD's, the prescription of medicines, medicine management and the safety and security of medicines.
- The medicines management audit for October 2018, demonstrated 89% compliance (amber). The summary identified:
  - some omissions in recording fridge temperatures on Orchard ward.
  - an out of date medicine had been found on Meadow ward and immediately removed.
  - private prescriptions were ordered through stores and then secured and locked away by a clinical member of staff once received on the ward.
  - The action included contacting relevant heads of department to discuss the concerns.
  - The safe and secure audit from July 2018 to October 2018, had an overall score of 94%. The summary found that not all patients always stored their medicines in the wall lockable cupboards provided because they wanted easy access to them.
- Actions taken to address this were recorded as "non-applicable". This was not in accordance with the hospital procedures for the self-administration of medicine.
- Medicines and equipment for use in emergencies were ready accessible to staff and were checked regularly.

**Incidents**

- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- We reviewed nine serious incident investigations provided by the hospital. We saw evidence that the hospital conducted robust investigations into each incident and when necessary identified areas that needed improvement. Action plans relating to each incident reflected learning and we saw that meeting minutes captured shared learning. We saw that incidents (serious or not) were discussed amongst teams to ensure awareness and where possible prevention of reoccurrence.
- From July 2017 to June 2018, there had been a total of 657 clinical incidents and 137 non-clinical incidents reported across the hospital. Of the 657 incidents within the hospital, 534 were categorised as no harm, 100 were low harm and 21 were moderate harm. There were no severe harms reported. The hospital recorded two deaths. We saw that incidents had been fully investigated, immediate actions were taken and lessons were learned
- Between July 2017 and June 2018, there had been 470 clinical incidents in for the surgical service. These included a bladder perforation following a cystoscopy and the retention of a central venous catheter cuff.
- Most staff recognised incidents and reported them appropriately. However, the RMO told us that they had never reported an incident and if one occurred would report their concerns to their employing agency.
- The hospital used an electronic incident reporting system which all staff had access to. Staff we spoke to knew how to report incidents and gave examples, for example data breaches, extended length of stay, infections and staff incidents. Managers told us that there was a good reporting culture and that staff were supported to report incidents if necessary.
- Managers reviewed the care delivered and investigated incidents to ensure that lessons were learned and shared with the team. For example, staff told us that following an unexpected patient death there had been education and training. We saw that training had been provided for staff in the importance of monitoring and accurately recording patient's fluid balance. However, this was not fully embedded as we saw that not all fluid balance charts were fully completed.
- Staff told us they received feedback from incidents. Managers provided feedback and learning from incidents in several ways. These included the daily safety 10 at 10 meeting, ward and department meetings, individual feedback and discussion from root cause analysis (RCA's) of incidents. Staff told us that they found the discussions from RCA's particularly helpful.
- Staff understood the duty of candour and explained how and when this would be applied. We saw from incidents that we reviewed that the duty of candour had been applied.
- There had been no never events reported in the last 12 months. Never events are serious incidents that are

entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

- Following an unexpected patient death in May 2017, the service had reviewed the care and treatment plans for all patients who, for their own personal reasons or beliefs, refused blood transfusions. Managers had worked collaboratively to review the patient pathway to minimise the risk to future patients, this included ensuring that surgery was booked six weeks in advance and that all staff involved, including a consultant haematologist, were informed to support the optimisation of patient treatment. Managers had met with Jehovah's Witness liaison officers and had delivered staff training to improve their understanding of patient personal beliefs and preferences. These patients acknowledged the steps taken to improve patient safety**.**
- Senior managers informed heads of department of any central alerting system (CAS) patient safely alerts. Heads of departments passed these on to staff if they were considered to be relevant. A recent CAS alert had been issued regarding oxygen cylinder flow, we were not assured that robust systems were in place as staff were unaware of this alert. We requested further information and were provided with a policy which was out of date. Therefore, we were not assured that the process was working effectively.

**Safety Thermometer (or equivalent)**

- **The service used safety monitoring results well.** Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- We saw that information relating to patients' safety was captured and analysed centrally by the corporate team. Information relating to the number of falls, pressure ulcers and venous thromboembolism (VTE) risks were compared to the hospitals peers. Data observed during inspection confirmed that the hospital was not an outlier for any category.
- The hospital monitored information equivalent to the NHS safety thermometer, including instances of pressure ulcers, falls, VTE acquired on admission and catheter-related urinary tract infections acquired during admission. Staff used care pathways to prevent avoidable pressure ulcers and falls. This included risk assessments and monitoring based on individual patient need. Data submitted to NHS England between December 2017 and November 2018 indicated 100% harm free care was provided with the exception of June 2018 which was 75%.
- Between July 2017 and June 2018, two cases of hospital-acquired VTE were recorded. In this period, the hospital was 99% compliant with VTE risk assessment standards using a monthly audit.
- There were VTE screening processes in place and the hospital had carried out audits. Audits showed that from July 2018 to September 2018, 30 records were audited, showing 100% compliance with VTE screening.

## Are surgery services effective?

Good

Our rating of effective stayed the same.We rated it as **good.**

**Evidence-based care and treatment**

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- A wide range of policies and guidelines were available for staff. They were based on national guidance and provided references to these. Updates on new policies were communicated via e-mails, ward and departmental meetings, posters and pay slips.
- Local policies and procedures and the National Institute for Health and Care Excellence (NICE) guidelines were discussed at clinical meetings and through the hospital medical advisory committee (MAC), with a log of all appropriate NICE guideline compliance reviewed.
- The hospital used evidence-based guidance and quality standards such as NICE NG45 "Routine pre-operative tests for elective surgery" (2016), to inform the delivery of care and treatment. The policies ensured guidance did not discriminate because of race, ethnic origin gender, culture, religion or belief, sexual orientation and/or age.
- The service participated in relevant local and national audits which were based on national guidance, standards and legislation, including NICE, the Royal College of Surgeons, and the Health and Safety Executive. For example, surgical site infections were

audited in line with NICE guidelines QS49 'Surgical site infections' (2013); and the audit of Patient Reported Outcome Measures (PROMS) and National Joint Registry (NJR).

- The hospital had an audit programme and collated evidence to monitor and improve care and treatment. The hospital participated in a local audit programme which was set corporately by the Ramsay Health Care group. The hospital benchmarked the results from audits with other hospitals within the Ramsay Health Care group. Audits included consent, resuscitation, hand hygiene, health and safety, the WHO surgical checklist and medicines management. We saw that actions were taken to improve compliance where indicated. For example, fluid balance charts were not being fully completed in theatre. Teaching sessions on fluid balance and irrigation were implemented as mandatory for all clinical staff.
- The theatre manager was new in post and confirmed they were currently ensuring the theatre action plan was implemented with all outstanding items being addressed. However, action plans were unclear. Core and local audits were undertaken including observational and retrospective audits with information obtained from the patient notes. There were plans to make changes but these were still in development. Cross site audits had taken place, action plans were completed and displayed. The use of fluid balance charts was being audited retrospectively.

**Nutrition and hydration**

- **Staff gave patients enough food and drink to meet their needs and improve their health.** They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Patients nutrition and hydration needs were assessed using MUST. This was in line with NICE guidance QS15 Statement 10: "Physical and psychological needs" 2012). MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition or who are obese. During the inspection, we did not see evidence of a MUST tool completed within the seven records seen.
- The service had a 'nil by mouth' policy. Patients waiting for surgery were kept 'nil by mouth' in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Staff followed guidance from the Royal College of Anaesthesia, Raising the standards (2012), and offered specially formulated drinks to patients up to two hours before surgery to ensure optimisation of energy (calories) and fluid before surgery.
- Patients were given clear instructions about fasting before admission. Information was given verbally at the pre-operative assessment and in writing. For example, patients were told not to eat for six hours before a general anaesthetic and were encouraged to drink clear fluids up to two hours before a surgical procedure.
- Staff informed the anaesthetist if a patient's surgery was delayed and checked if the patient could have a drink.
- Patients had jugs of water within reach. These were regularly refilled. We saw there was a water cooler on the wards so that patients could access additional drinks if they wanted. Staff had access to snacks and drinks, which they could provide to patients between mealtimes. This helped to support patients' nutritional intake and hydration. Patients told us that the food was satisfactory and that they were offered hot drinks frequently.
- During our last inspection, we saw that intravenous fluids were not always prescribed, administered or recorded appropriately. The hospital had focussed on intake and output and had implemented a training programme for staff. However, we saw that not all fluid balance charts had been fully completed nor were intravenous fluids always prescribed appropriately. We raised this with hospital managers who told us they were providing training for all staff and were piloting a new anaesthetic chart in theatres in other Ramsay hospitals with a specific area for fluid prescriptions. Senior managers planned to introduce these across all Ramsay hospitals. We were not assured that training on fluid balance was embedded
- Patients with nausea or vomiting were prescribed antiemetic medicine (a medicine effective against vomiting and nausea). Patients were given antiemetics intravenously in the recovery area if they complained of nausea post operatively.
- The hospital had a service level agreement (SLA) in place with the dietetic service for a local NHS trust for support and advice.
- The hospital had received a five-star rating for food hygiene in June 2018.

**Pain relief**

- **Staff assessed and monitored patients regularly to see if they were in pain**. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Pain was risk assessed and recorded using the National Early Warning Score (NEWS 2) scale and we saw these were completed. We observed staff asking patients if they were in any pain. Staff had access to tools to help assess the level of pain in patients who were non-verbal.
- The service met the core standards for pain management services (Faculty of Pain Medicine, 2015). Patients who were self-medicating could not self-medicate with analgesia. Medicines were given as prescribed and the effect of analgesia was individually evaluated. Staff assessed patients' pain regularly post operatively. Patient's told us that they had received effective pain relief when they needed it.
- Consultants and anaesthetists prescribed pain relief medicines for the immediate post-operative period. This included pain relief using pumps, if necessary. The registered medical officer (RMO) was available to provide further pain relief and advice for patients 24 hours a day, seven days a week.
- Information provided by the hospital stated that pain relief was audited as part of the patient journey audit. We reviewed the patient journey audit for July to September 2018, however, we saw that pain was not audited.
- Pharmacy staff reviewed all patients' pain relief needs and gave them advice on how best to take them, to optimise their effect. On discharge, patients were given leaflets to remind them to collect their prescriptions and contact numbers to call if their pain relief medicines were not sufficient or they needed more.
- The service held functional restoration programmes for NHS patients with chronic pain and monitored patient outcomes physically and emotionally.
- The hospital had a service level agreement (SLA) in place with a local specialist pain team. This meant that staff were able to access advice and support if necessary.

**Patient outcomes**

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.
- Information about the outcomes of a patient's care and treatment, both physical and mental was routinely collected and monitored. This was done through both local and national audits. Examples included the national joint audit, infection and prevention and controlled medicine s audits.
- Managers audited care bundles for example, peripheral venous cannula use, urinary catheter bundles and surgical site infections. Action plans were in place to address issues.
- The hospital participated in national audit programmes including the National Patient Reported Outcomes Measures (PROMS), Joint Accreditation Group (JAG), national joint registry (NJR), breast implant registry, Private Healthcare Information Network (PHIN) and Patient-Led Assessments of the Care Environment (PLACE).
- The hospital participated in the National Patient Reported Outcomes Measures (PROMS) for hip and knee surgery for NHS patients. PROMs for hip and knee replacements were followed up at six and 12 months. Patient outcomes were also monitored through the reporting of clinical outcomes on the hospital reporting system. Managers reviewed practice to ensure that any trends were identified and changes were made to improve patient outcomes. PROMS were reviewed at quarterly clinical governance meetings. The data showed that surgery and health gains were within the national average for hip replacement. The data for knee replacement showed that surgery and health gains were below the national average for knee replacement.
- Patient Related Outcomes (PROMS) were used to manage and improve performance. The service monitored infection rates for joint replacement surgery, spinal surgery and abdominal hysterectomies. From July 2017 to June 2018, the service had reported three surgical site infections out of 276 operations for primary hip replacements, two surgical site infections for primary knee replacements out of 305 operations and one gynaecological infection out of 941 operations. The service had 100% compliance with reporting Surgical Site infection to Public Health England (PHE) and the Health Protection Agency (HPA). PROMs for cataract surgery were introduced in 2017.
- The hospital participated in the National Joint Registry with 98.5% compliance reported over the period April 2017 to March 2018

- The service held functional restoration programmes for NHS patients with chronic pain and monitored patient outcomes physically and emotionally.
- The hospital participated in the Patient-Led Assessments of the Care Environment (PLACE) audit. The assessments involve patients and staff who assessed the hospital and how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. Results from the 2018 PLACE audit demonstrated that the hospital scored 100% for cleanliness, 96% for food, 84% for privacy and dignity, 82% for dementia and 79% for disability care. The hospital scored higher than the national average on all measures apart from privacy, dignity, wellbeing and disability.
- The service completed the patient journey audit from July to September 2018. This included the national early warning score (NEWS) score, pain score and fluid intake and output. The service had focussed on intake and output and had implemented a staff training programme. This had been audited and was to be reviewed in three months to monitor performance, compliance and highlight any good practice or weaknesses.
- The service had a laser protection adviser from an NHS trust who provided support and was contactable for any queries. The laser protection adviser undertook the annual audit and reviewed theatre and out-patient lasers. Following the audit in June 2018, relevant folders and documents were updated.
- There had been 22 unplanned in-patient transfers to another hospital from July 2017 to June 2018, 48 unplanned readmissions within 28 days of discharge and 17 unplanned returns to theatre in the same period. Complications of surgery were recorded as incidents and were investigated and discussed at clinical governance meetings.

**Competent staff**

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- There were 248 consultants who worked at the hospital through practicing privileges. These were monitored by the senior management team (SMT) to ensure that competence, appraisals and revalidation were kept up to date. The SMT liaised with consultants' base hospitals to ensure compliance with appraisals and to ensure that consultants were working within their scope of practice.
- When a consultant wanted to perform new procedures, a robust process was in place whereby an application was made by the proposing consultant. The process included details of the benefits to patients, evidence of competence and details of costings to the hospital. The medical advisory committee and SMT reviewed the application prior to the request being forwarded to the corporate approval committee.
- Any concerns with competence were managed by the SMT with guidance from the medical advisory committee, specialists or the corporate team. We were given examples of when competence had been reviewed and practising privileges adjusted according to findings. Staff reiterated that any concerns over practice were challenged, this included any recurrent themes in complaints or incidents.
- Medical staffing appraisals were completed by the consultants' base trust, although the Medical Advisory Committee had oversight of performance and appraisal details. Consultants who did not provide appropriate evidence had their practising privileges suspended until the evidence was produced.
- The hospital provided a training plan which included mandatory and non-mandatory topics. For example, we saw that topics such as risk reporting, cancer services, managing difficult customers and cosmetic surgery were taught in sessions from October to December 2018.
- Resident medical officers (RMOs) had their mandatory training provided and competencies assessed and updated by their employing agency. Before commencing work at the hospital, the RMO's curriculum vitae (CV) including employment history, training certificates, qualification certificates, references and certificate of enhanced disclosure and baring service (DBS) were forwarded to the director of clinical services. Any concerns about their practice were escalated to the provider agency. Any training needs that were identified, were raised with the clinical lead and medical director and training took place. If an RMO was identified as needing support a second RMO was put in place.
- The service had an induction policy, this was up to date. Staff told us they received a comprehensive induction when they commenced work at the hospital. This

included a hospital wide induction and local induction. The local induction included; orientation to the area and local competencies. The hospital wide induction included; information governance, infection prevention and control and fire safety. Staff said they found the inductions helpful. Bank and agency staff also had an induction to the local area.

- Training and development needs were identified through the appraisal process. All nursing staff and operating department practitioners (ODPs) had had an appraisal within the last year and 92% of health care assistants (HCAs). On the ward areas 75% of staff had had an appraisal. Managers told us this was because some staff were on maternity leave. All staff we spoke to told us that they had had an appraisal and that they found the process to be helpful and enabled them to identify learning, development needs and to take on additional roles.
- Managers supported staff training and development to improve staff competence, skills and confidence. These included staff apprenticeships, national vocational qualification training (NVQ), nurse training, mentorship and preceptorship. Staff told us that they had been supported to develop, for example staff had undertaken a mentorship course with the local university to support student nurses in practice. Student nurses told us that they had been well supported during their placement.
- The service had a policy for clinical supervision. Staff told us that they had clinical supervision but it was infrequent and not formalised. The sister on duty would talk through any issues with the staff member.
- The service had practice educator who oversaw the ongoing education and training of staff, assessed competencies and supported staff to attain them. The service did not have an intravenous (IV) fluids lead but the practice educator was providing training on the accurate completion of fluid balance charts. We saw that training had taken place and that documents had been developed which were included in each patient's record to support the accurate completion of fluid balance charts. However, we were not assured that this training was embedded in practice as some fluid balance charts were not fully completed at the time of our inspection. Managers were aware of this and planned to re-audit compliance.
- There were competencies in place, which were general to the Ramsay Health Care group. These included intravenous medicine administration and use of ward equipment. Competencies were initially self-assessed followed with an evaluation by the ward manager or a competent or experienced practitioner. All staff had a competency file, we saw that these were fully competed.
- The service had named lead practitioners, link nurses and champions in key areas including safeguarding, dementia, and infection control who provided comprehensive education and support in practice and undertook audit. Support was also available from The Ramsay Health Care group specialist staff. The service had recently appointed an inflammatory bowel disease (IBD) nurse specialist to support patients seen in clinic who are on long term treatment programmes and provide support to staff.
- Managers had significantly increased the number of staff with ALS training on the ward and in theatre. Where any gaps in knowledge were identified training was implemented. For example, following an incident where patients had refused blood products, managers had liaised with specialist groups and had delivered staff training to improve understanding of patient's personal beliefs and preferences.
- Lessons learned sessions had been introduced following incidents where patient harm had occurred. Staff told us that they found these sessions particularly useful.
- Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and one to one meetings with their managers
- Nursing staff were required to demonstrate that they were fit to practise under the "code, professional standards of practice and behaviour for nurses and midwives." Staff confirmed the hospital had supported them to complete their revalidation in line with their registration requirements when required.

**Multidisciplinary working**

- **Multidisciplinary teams (MDT) worked well together to improve the effectiveness and timeliness of care.** Relevant staff teams and services were involved in assessing, planning and delivering patient care and treatment and worked together to understand and meet the range and complexity of patient needs. We observed patient care on surgical wards was supported by a variety of teams. This included pharmacists and physiotherapists.

- Heads of department attended a daily communication meeting which included assessing any risks to patients, reviewing staffing levels, sickness, training and maintenance issues.
- The pharmacy worked well with staff on the surgical wards and provided the following services; medicines reconciliation, an assessment of the patient's own medicines and medicine history gathering.
- Staff providing the pre- assessment service were supported by the medical team when they identified concerns about a patient's fitness for surgery and said they had a good working relationship with the consultant anaesthetists. Patients families were involved in the pre-assessment process, planning, delivery and discharge arrangements as necessary.
- The hospital had good working relationships with local NHS acute trusts for transferring patients in line with agreed pathways. Consultants with practice privileges, mainly came from the local NHS trust. This helped to build good working relationships.
- The service had links with specialist staff at the local NHS trust, for example the dementia care nurse and dietetic service.

**Seven-day services**

- **The surgical service provided a six-day service, with procedures completed on Sundays when required due to changes in the patient's condition.**
- The hospital only undertook elective surgery, and operations were planned. The exception to this was if a patient needed to return to theatre due to complications following a procedure.
- The hospital did not provide surgical procedures seven-days a week. However, operating lists ran from 8am Monday to Saturday with two slots of four hours. Each operating list had a 30-minute slot allocated for a team briefing, preparation and decontamination. Some lists were eight hour all day operating lists. The service did not routinely operate in the evening.
- There were on call arrangements in place to provide staffing if a patient needed to return to theatre.
- The hospital offered outpatient clinics from 8am to 9pm Monday to Fridays and from 8am to 3pm on Saturdays. Theatres offered routine sessions from 8am to 6pm across the working week. Some slots extended to 8pm but the hospital tried to avoid sessions running late into the evening.
- Consultants were on call 24 hours a day for patients in their care. There was 24-hour RMO cover in the hospital to provide clinical support to consultants, staff and patients.
- Consultants provided details of cover arrangements for when they were not available. This was a requirement of their practising privileges.
- A senior nurse was always available for advice and support during working hours. Furthermore, the management team operated a 24-hour, seven day a week on-call rota system where staff could access them for advice and support as needed.
- Radiologists supported the hospital out of hours or at weekends and attended the hospital if the consultant in charge requested their support.
- Pharmacy was open Monday and Tuesday form 9am to 8.30 pm, Wednesday to Friday 9am to 6pm and from 9am to 2pm on Saturday. There were on call arrangements from 8.30 pm to 9am Monday to Friday, 2pm to 9pm on Saturdays and 8am to 8pm on Sundays.
- A pathology laboratory was on site and available seven days a week. The laboratory was run by a third-party company.
- Physiotherapists were available seven days a week, either on site or on call by arrangement.
- A blood bank was on site with access to blood and transfusion services seven days per week.
- The service linked with the hospice for dementia awareness and dementia friends training. A connection had also been made with the dementia link nurse in the local NHS trust.

**Health promotion**

- **Where possible, staff encouraged people to have healthier lives, offering advice and services relating to aspects such as smoking cessation and healthy diets.** There were a large number of information leaflets available for patients and their relatives relating to specific clinical conditions and how to access support.
- Patients attended pre-operative assessment appointments where their fitness for surgery was routinely checked. They were provided with a booklet of advice about their hospital stay.
- Staff identified patients who may need extra support. We saw health promotion information and materials on

display on the wards. Examples included; eating a healthy diet, dementia care and support for relatives, increasing physical activity and specific information about surgery.
- The physiotherapy staff saw patients who were to undergo orthopaedic surgery. These appointments provided health promotion opportunities, including exercises on how to maintain mobility.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- **Staff understood their roles and responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**
- The MCA protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). None of the patient records seen required an assessment regarding their capacity.
- The service had an up to date consent policy. From our last inspection in June 2016, not all staff at all levels were clear about a patients' consent for surgery. During this inspection, nursing staff were clear about their responsibilities in relation to gaining consent from people including those who lacked capacity to consent to their care and treatment. There were no admitted patients who lacked capacity during our inspection.
- We looked at seven sets of patient records. Consent forms had been clearly completed with signed authorised forms for treatment and exploratory investigation during the inspection. Six of the seven consent forms seen were signed on the day of surgery although patients had had a consultation with the consultant to discuss surgery prior to admission. Consultants sought first stage patient consent in the out-patient clinic with second stage consent being sought on the day of surgery. The service completed planned and responsive audits of consent forms to ensure they were completed appropriately.
- All patients having breast implants were provided with information about their surgery, the implants and the risks involved when they saw the consultant in clinic. All cosmetic patients had a two-week cooling off period before surgery. Patients had a pre-operative assessment with a specialist nurse who discussed the breast implant registry, and provided a patient information leaflet to read prior to their admission. On admission the consultant sought consent from patients for their details to be recorded on the breast implant registry.
- Staff told us that patients with complex needs would be involved in a pre-operative meeting with their family, friend, carer and consultant in order to put a plan in place for their admission. Family members or carers were encouraged to stay with the patient and operating lists would be adjusted to suit patient need.
- Staff described when DoLS might be needed. Staff explained that they would contact the director of clinical services and involve the consultant and relatives if they had concerns about a patient. Staff told us that it was rare that they received referrals for treatment for patients with dementia or learning disabilities and had not had to make a DoLS application.

## Are surgery services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

**Compassionate care**

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. Patients praised staff for their kindness and individual understanding of their needs.
- Staff promoted privacy, and patients were treated with dignity and respect. We observed staff spending time with the patients, and interacted with them during tasks and clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- Feedback from patients confirmed that staff treated them very well and with kindness. Staff respected

patients' privacy and dignity during personal care, for example, staff pulled curtains around the bed space. The Patient-Led Assessment of the Care Environment (PLACE) in August 2018, regarding respect and dignity was 98.9% which was above the national average of 84%.

- The service obtained feedback in several ways. Patients had two surveys in their room. The 'we value your opinion' enabled patients to provide any comments that they wanted to share with management for example about food, hygiene and cleanliness. The patient satisfaction survey form, which was sometimes taken home and returned. Patients could add any free text that was relevant to their stay. Patients also posted feedback online on NHS choices and social media.
- The hospital obtained patient feedback through the Friends and Family Test (FFT), which allowed patients to state whether they would recommend the service and give feedback on their experiences. Between February and July 2018 monthly scores were 100% with exception of 98% in May 2018. However, response rates were low, ranging from 5% to 9%.
- Patients received an electronic survey or phone call following discharge for feedback on their experience. There were posters in reception and around clinical areas with details about how to feedback and complain.
- We saw examples of thank you letters that staff had received displayed in the clinical areas. There were many positive comments, one patient had written "nothing is too much trouble for nursing staff, catering staff, cleaners and doctors, all are helpful". One patient told us that they "had received excellent care and treatment".
- Patients told us that they would be happy for their friends and family to come to the hospital for treatment.

**Emotional support**

- **Staff provided emotional support to patients to minimise their distress.**

- Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. Patients said they were happy with the explanations given to them from the medical and nursing staff.
- Staff understood the emotional stress of patients having an anaesthetic prior to a procedure. One patient said staff were very supportive and they felt safe and had all their questions answered. Post-operative care within the recovery area was sympathetic and staff did everything they could to ensure patients were comfortable and free from any pain
- Nursing staff showed an awareness of the impact that a patient's care, treatment or condition could have on their well-being and those close to them. Patients were given information about relevant counselling services and peer support groups where applicable.
- Referrals could be made by staff to a chaplaincy service if required by patients.

**Understanding and involvement of patients and those close to them**

- **Staff involved patients and those close to them in decisions about their care and treatment.**

- We received 17 "tell us about your care" cards completed by patients and relatives. Without exception, all comments were positive, with the majority referring to an "excellent service". We also received comments such as "The staff from the receptionist to the physios are very welcoming, caring from start to finish", "the care I have received has been first class. The staff are very caring and have made me feel quite special and treated me with dignity".
- All patients referred to being "listened to". There was also one comment which stated that one staff member had "been of great help to me, as they pushed me to return to my GP about another condition which has been caught in time. So very happy with my treatment".
- Patients said they felt involved in their care and had been asked for permission and agreement first, which meant that the views and preferences of patients were considered. Patients and relatives confirmed they had been given the opportunity to speak with the consultant looking after them. Patients said the consultants had explained their diagnosis and that they were fully aware of what was happening. All patients were complimentary about the way they had been treated by staff. We observed that most staff introduced themselves to patients, and explained to patients and their relatives about the care and treatment options.
- Staff recognised when patients and those close to them needed additional support to enable them to be

involved in their care and treatment. Staff said they had systems in place to identify the communication needs of patients which included access to language interpreters, specialist advice or advocates when required. This meant the service was compliant with the Accessible Information Standards (2015). These standards direct and define a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

- Staff took time to explain information to patients in an appropriate manner while making sure patients knew how to contact them if they needed more information.
- Information was clearly displayed on a noticeboard on the ward for carers, services to access and dementia care to provide support.
- Patients who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

## Are surgery services responsive?

Good

Our rating of responsive stayed the same.We rated it as **good.**

**Service delivery to meet the needs of local people**

- **The service planned and provided services in a way that met the needs of local people.** The service only received planned admissions. Managers monitored the pre-assessment process to ensure all patients at risk were identified.
- Due to the location of the hospital, car parking was limited. This was further impacted by the inappropriate use of the car park by local residents to use the nearby green space. This meant that temporary parking was organised during the summer on a grassy area which met the needs of visitors and patients. However, during the colder and wetter periods this area became impractical to use which impacted on patient experiences. In response to this, the SMT had arranged for a hardcore surface to be placed in the area, and they were looking at restricting parking and using a car parking warden. However, this was not in place, and there was no time scale. Public transport was available.
- The hospital was committed to providing surgery to private patients as well as providing services for NHS patients through agreements with the local commissioners. Information provided by the hospital stated that all patients were treated equally whether self-funded, through insurance schemes, or through the NHS.
- There was written information available about most types of planned treatment. Information included details of their planned length of stay, after care in hospital and following discharge to ensure an optimal outcome from their treatment. We saw information available on the wards. The patient journey audit from July to September 2018 demonstrated 100% compliance, based on 30 records, with providing patient information.
- Planning the delivery of the service was coordinated at daily management meetings. The meetings ensured the needs of different patients were considered when planning and delivering services.
- Services were planned in a way which ensured flexibility and choice. For example, the theatres and endoscopy service offered weekend appointments for patients who were unable to attend on a weekday.
- The booking system was conducive to patient needs in that where possible, patients could select times and dates for appointments to suit their family and/or work commitments.
- Theatre lists for elective surgery were planned with the theatre manager and the bookings team. This helped to ensure operating lists were utilised effectively and patient choices were accommodated wherever possible.
- The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions to hospital, to make best use of its beds, and to discharge patient's home in a timely way.
- The hospital had service level agreements with a local acute hospital to provide extra services they were unable to supply themselves. This included pathology services, critical care services and nutrition and dietetic services.
- Patients told us that staff responded quickly to call bells. The service had a system where the patient could ring the bell and speak to a member of staff through an intercom system. We saw staff responding quickly to patient's needs.

Good

# Surgery

**Meeting people's individual needs**

- **Services were planned to consider the individual needs of patients. Adjustments were made for patients living with a physical disability. The hospital had disabled access across all areas of the service.**
- Managers monitored the patient pathway and identified patients with individual needs and co-morbidities early. This avoided patient harm and assisted in safe discharge planning.
- The service linked with the hospice for dementia awareness and dementia friends training. Staff had also made links with the dementia link nurse in the local NHS trust.
- The service had made improvements to the hospital facilities through refurbishment and the opening of a new day surgery unit. Equipment had been upgraded including new stack systems in theatres.
- The hospital offered face to face and telephone interpreting for spoken languages, translation services (including braille) and British Sign Language interpreters. Staff knew how to access the translation services when required.
- Reasonable adjustments were made to take into account the needs of different people on the grounds of religion, disability, gender, or preference. For example, training had been provided about meeting the needs of patients who refused to have blood or blood products for religious or personal reasons.
- During our inspection, we did not see any bariatric equipment in the clinical areas. For example, there were no large size commodes for patients. However, staff told us bariatric equipment was available and could be hired when required for specific patients.
- Patients told us that they were given detailed explanations about their admission and treatment in addition to written information. We saw clear explanations and reassurance being given to patients who were about to undergo a procedure in theatres. Staff provided information leaflets for a range of conditions and to support care given. These were written in English but could be obtained in other languages.
- Staff answered call bells promptly; patients also told us that nursing staff responded quickly to their needs, for example to help them to the toilet.
- The service's Patient-Led Assessment of the Care Environment (PLACE) audit for 2018, which looks at how the environment supports patients living with a disability scored 79.9% This was lower (worse) than the England average of 84%. However, the PLACE audit for dementia for 2018 was 82.4% which was better than the national average of 78.9%, however this had deteriorated from 2017 when the score was 87.2%.
- The PLACE audit for 2018 for food and hydration showed they scored better than the England average of 90.2% at 96.2%.
- Patients had access to drinks by their bedside and snacks were available on request if required. Water dispensers were available for patients, staff and visitors. Patients told us the quality of the food was good and provided a choice of menu.
- The service reviewed how it communicated with patients on a regular basis and updated this as required.

**Access and flow**

- **People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- There was a streaming process in place upon arrival to the hospital. There were two checking in streams, one for private patients and another for visitors and patients. Staff told us this had reduced the waiting time at reception.
- The hospital had a patient journey policy. It set out the process staff should follow when assessing, admitting, treating and discharging patients. All admissions had to be agreed and accepted by a consultant and a booking form completed.
- There were effective processes in place to ensure patients were offered appointments and treated within reasonable timeframes. Waiting times were monitored and reported monthly. The hospital submitted data based on NHS referral to treatment (RTT) guidelines. From April 2018 to July 2018, the hospital achieved between 98.5 to 100% compliance with the RTT waiting times for non-urgent consultant-led treatment. Patients waiting more than six weeks from referral to a diagnostic test was 0%.
- Private patients were guaranteed an outpatient appointment within 72 hours. Private patients did not

have a wait time for surgery and could be added to the next available list if this was convenient for them. Patients told us that they had been seen quickly by all staff.

- The hospital's admission policy and local contracts ensured patients received a pre-operative assessment. All patients were assessed and this meant patients were identified as being safe for surgery. This also ensured that all pre-operative tests, investigations and results were available, unnecessary cancellations were avoided where possible. Any patient who was deemed unsafe to proceed at Rivers Hospital was referred to the GP to discuss options or directly to the local NHS trusts if appropriate.
- The number of admissions and planned treatments reduced at weekends with the provision of only one operating list on Saturdays.
- Anaesthetic clinics had been established for patients with increased complexity. This aimed to avoid cancelling operations and providing an improved service.
- Theatre staff provided an on-call theatre team who were called to attend any emergency readmissions to theatre. Additionally, in the event of a patient deteriorating and requiring higher levels of care, the patient was transferred to the local NHS trust via ambulance.
- The service had opened a new day surgery unit in 2017, which had improved the day surgery patient pathway. The service had received positive patient feedback.
- Discharge arrangements commenced with the pre-operative assessment. Discharge information was sent to GP's, this included details of the patient's treatment, out-patient appointments and medications.
- From July 2017 to June 2018, the service cancelled 1080 procedures for non-clinical reasons. All patients were offered another appointment within 28 days of the cancellation. The service reported 17 unplanned returns to theatre and 22 unplanned transfers to other hospitals. These were all reported and logged as incidents. In same time frame, there were 48 unplanned re-admissions within 28 days of discharge.

**Learning from complaints and concerns**

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- There was a management of patient complaints policy in place which was a Ramsay Health Care UK group policy. We saw that the policy was in date and identified responsibilities and processes for managing complaints, including timeframes for completing complaint investigations and responding to complainants. Timelines were occasionally extended if further evidence was required.
- Complaints management was the responsibility of the senior management team (SMT), namely the hospital director. Upon receipt of a complaint, a holding letter was forwarded to the complainant in acknowledgement of the receipt. Each complaint was investigated by the most relevant person, for example, clinical concerns were investigated by the head of clinical services, a specialist or consultant and a repose formatted according to the investigation findings. We saw that when necessary, with complex concerns, the complaint was kept informed of the progress and if necessary response timelines adjusted.
- We reviewed a selection of complaints and their responses. We saw that responses were clear, easy to read and included full explanations of concerns raised. Apologies were always offered. Complainants were always offered a conversation or meeting to discuss their concerns and the investigation outcomes.
- All concerns, complaints and comments were reviewed to identify themes which enabled the SMT to take any necessary action.
- The medical advisory committee were cited on complaints relating to clinical practice and consultant performance. We were told that meetings would discuss themes and actions and ensured confirmation of best practice from the specialist lead on how they should be managed. Meeting minutes confirmed this. We saw that complaints were discussed as part of the wider team.
- Managers informed patients about the complaints procedure. We observed literature on display advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- Patients told us that they had no reason to make a complaint but that they would feel confident in raising a concern or complaint if necessary. Staff told us that they would try to resolve any concerns immediately. If this was not possible the complaint was referred to the ward manager or nurse in charge.

- Unresolvable complaints were recorded on a centralised complaints system. Those that were resolved in the moment were not always recorded on the system as a complaint, therefore we could not always be assured that lessons were learnt.
- The service reviewed the care delivered and investigated incidents and complaints to ensure that lessons were learned and shared with the team. Staff told us they received feedback from complaints from various sources including ward meetings and handovers. Meeting minutes confirmed this.
- From January 2018 to June 2018, the hospital had received 29 complaints, one was referred to the Ombudsman. Of these 10 related to the surgical service. The top two themes included the outcome of surgery and care and treatment by nursing and medical staff. We saw that necessary actions had been taken to address the complaints, improve the quality of care and the service. Complaints were discussed at ward and department, senior management, heads of department and clinical governance meetings and actions to be taken were discussed. The hospital also recorded any verbal concerns raised which were resolved locally.
- The service received verbal or written feedback from patients unhappy with aspects of their care. Managers offered to meet patients and their families to fully investigate any concerns. Managers would inform patients either face to face or in writing about the response to complaints and actions taken.
- There was a 'Hot Alerts' once a week where patients had provided permission to be contacted by managers to provide them with positive or negative feedback.

## Are surgery services well-led?

Good

Our rating of well-led stayed the same.We rated it as **good.**

**Leadership**

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- Rivers Hospital is part of the Ramsay Health Care UK Operations Limited group. The corporate structure includes an executive board, which were informed by several committees and groups. The senior management team (SMT) reported into the corporate leads and were supported through a network of regional and national leads and specialists. Staff told us that the corporate team were accessible and responsive to their needs. We were given examples whereby staff had contacted key corporate leads for advice and support with specific issues.
- The leadership at the hospital mirrored the corporate structure, with a number of committees feeding into the risk management board and the operations board. For example, information governance, human resources, financial governance and clinical governance feed into the risk management board. Marketing and communications, procurement, development committee and diagnostics committee feed into the operations board. All this information fed into the executive board which was also supported by the national medical advisory committee.
- Locally the SMT consisted of a hospital director, head of clinical services (matron), site operations manager and a finance manager. Heads of department or leads were in place for each speciality and service.
- The hospital director had been in post for approximately six months at the time of inspection. This coincided with a number of changes to the heads of department, and although the new team were not fully established it was clear that the changes in local leaders had refreshed the aims and objectives of clinical areas. For example, the hospital director had used the opportunity of a retirement to adjust the structure of the surgical leads. Services had been split into ambulatory and inpatient services. Ambulatory services included outpatients, oncology services and day case services. Inpatients services consisted of the ward area. We were told that this had given the SMT the opportunity to look at additional services which could be offered and would enable local leaders to assist with these developments.
- Staff told us that the SMT were visible and approachable. We saw that they were seen regularly on the ward and attended safety briefings daily. There were plans to reduce the SMT attendance at the safety briefings so that only one member of the team attended, however, it was acknowledged that the meetings provided an ideal opportunity to meet staff and discuss any new topics.
- Managers in theatre, the ward and pre-operative assessment units were all new in post. However, all

managers had clear ideas of how they wanted to develop their services and where they needed to focus to make improvements. For example, the theatre manager was actively recruiting staff, introducing quality meetings and addressing key risks on the risk register. The pre-assessment manager planned to improve efficiency by increasing the numbers of face to face pre-assessment appointments, including introducing weekend appointments and developing new systems for pre-assessment telephone calls. There were further plans to forge links with other pre-assessment leads within the Ramsay group to share knowledge and experience.

- Staff told us that the senior management of the hospital were visible and respected. Nursing staff said that the general manager and matron were supportive and accessible.
- Department managers told us that they felt well supported by senior management. Managers told us that they had an open-door policy and they spoke with pride about their staff, support for each other and their hard work. Departmental staff told us that they felt well supported by their managers and were encouraged to develop their knowledge and skills.
- We met with the ward managers and registered nurses during the inspection and found they demonstrated a strong and supportive leadership. When we raised issues with them, they responded to address them immediately. The managers worked clinically and provided clinical cover for sickness when required. We saw that ward and theatre staff worked well together.
- There had been key focus on improving communication across the hospital. Daily 10 at 10 communication meetings were held, drop in sessions to talk to the leadership team, staff forums, and regular updates from heads of departments in departmental meetings took place. Staff told us that the senior managers management "drop in" session were very useful.
- Staff we met with were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.

**Vision and strategy**

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**
- The corporate vision was long standing and embedded. Locally, the SMT had developed a ten-point quality improvement plan in line with the corporate vision. The associated action plan detailed who was responsible for each point and a review date. For example, we saw that improved communication was the responsibility of the hospital director. The improved communications included staff drop in sessions, "10 at10" safety briefings and the introduction of a newsletter. These actions were reviewed by the heads of department.
- We saw the corporate vision was displayed across the hospital.
- The hospital had a five-year vision and strategy (2018 to 2023) based on five key themes which included:
- 'Be the number one private provider in Northamptonshire and surrounding communities.
  - Expand the day case capabilities and expand inpatient in new service areas.
  - Build long term partnerships with stakeholders.
  - To lead on quality in Hertfordshire and surrounding areas
  - Become the health care employer of choice.'
- Staff told us that the service vision was aligned to the corporate vision and was to provide safe and responsive patient care. They told us that the new general manager had been pro-active in listening to staff and how they would like to see the service improve. The theatre manager told us that the vision was being developed but reflected the Ramsay values "to deliver excellent, affordable care to all patients with the best team in the sector"

**Culture**

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- There was a long standing corporate expectation with regards to culture called "the Ramsay way". This included:
  - We are caring- we are caring, progressive, enjoy our work and use a positive spirit to succeed.

- Sustainable- we aim to grow our business while maintaining sustainable levels of profitability, providing a basis for stakeholder loyalty.
- Working together- we believe that success comes through recognising and encouraging the value of people and teams.
- Positive outcomes- we build constructive relationships to achieve positive outcomes for all
- Value people- we value integrity, credibility and respect for the individual.
- We have pride- we take pride in our achievements and actively seek new ways of doing things better.

- Staff referred to "the Ramsay way", when discussing the treatment and care of patients. We also saw that posters were displayed across the hospital detailing each value.
- Staff reported a positive culture across the hospital. Consultants were happy to work at the hospital and felt that they were listened too and actions taken if necessary. We were told that medical staff worked as part of the team and supported a positive working environment. Staff reported that there was a common purpose.
- Staff completed a corporate staff survey annually. Local results showed that staff did not feel appreciated, there was a little knowledge of CPD and no reward, poor support offered to teams with decision to treat for complex cases, PDRs were not always completed or valued, fear of flexi leave not to continue and a request for this to be continued, lack of team involvement with decision making, introduction of evening theatre times, review of off duty process to produce greater flexibility. The senior management team had worked on the feedback from the survey and were planning to repeat the survey in January 2019 to identify areas of improvement.
- Since commencing in post, the hospital director had encouraged a positive culture and embedded expectations of roles and behaviours. We were told of engagement events with consultants and substantive staff which included social functions and recognition of contributions. The staff member of the quarter had been changed to staff member of the month, and they had also introduced a team of the month. Staff were asked to nominate individuals or teams and the SMT then picked a team who would receive a token gift in recognition of their hard work.
- In addition, the hospital director had revised the staff briefing sessions. Heads of departments were asked to allocate staff to attend briefing sessions, and discuss any concerns or thoughts. This process had enabled the HD to meet all staff and get their opinions on the things that mattered to them.
- Nursing staff on the wards reported a good culture. Staff felt supported by their colleagues and leaders in their individual areas. They told us they were proud to work within the hospital. Staff said their line managers looked after them well. We also observed positive and supportive interactions between matrons and ward managers. Heads of departments described having an open-door policy where any member of staff could see them privately. This was confirmed by staff spoken with who felt they could address any concerns with the matrons and managers.
- Ramsay Health Care UK Operations Limited had launched its "speaking up for safety" programme in July 2018. This was a two-part project. The first component was the speaking up for safety, which was an assertive communication model. The model promotes and empowers staff to make challenges when people are placed at risk. The second part was due to be launched in January 2019 and promoted professional accountability. This is through an online feedback system, which will capture comments from staff about peoples' performance. This system has been designed to be used to capture any feedback relating to people's attitudes and behaviours outside any areas of risk. Staff spoke openly about the planned project and told us that the capturing of this information will enable staff to identify any themes and enable challenge to be given.
- All grades of staff told us that they enjoyed working within the department and said that "there was a really good team", staff "support each other" and they "were very happy here". Many staff told us that they had worked in the department for many years. Some staff had left but returned because "it was a good place to work".
- The hospital culture encouraged openness and honesty. Processes and procedures were in place to meet the duty of candour. When incidents had caused harm, the duty of candour was applied in accordance with the regulation. Staff confirmed there was a culture of openness and honesty and they felt they could raise concerns without fear of blame. Staff said they were proud of the team approach and the duty of care.
- Most staff felt valued and supported to deliver care to the best of their ability. Openness and honesty was

encouraged at all levels and staff said they felt able to discuss and escalate concerns without fear of retribution. All staff spoken with talked about an open and transparent culture within the hospital. Quotes from staff included, “everyone is friendly”, “I love working for the hospital” and “we work well as a team.” Staff also confirmed they enjoyed caring for their patients and we observed good interaction during the inspection.

- Staff told us that there was a culture of no bullying at the hospital. Staff said that there had previously been a bullying issue but managers had dealt with this and it was no longer a problem.
- A Ramsay Group initiative 'Speak up for Safety ' had been added to the staff training in July 2018. More than 45% of staff had experienced the programme. The aim of the programme was to encourage and empower staff to challenge anyone, including senior colleagues, who may be putting patients at risk with their behaviour. The programme included assertiveness training for all staff and this was being rolled out to staff. Staff spoken with were very positive about the programme and we saw SUFS champions identified through the wearing of badges.
- There was a freedom to speak up guardian, staff were aware of who this was and how to contact them.

**Governance**

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- The governance structure mirrored that of the corporate team. There were a number of meetings which occurred at regular intervals, and fed up to the corporate meetings for review. Reports were prepared by subcommittees which fed into the Medical Advisory Committee (MAC), Health and Safety Committee(H&SC) and the Clinical Governance Committee (CGC). The MAC, H&SC, CGC were completed bi-monthly, and information reported into the weekly senior management team (SMT) and the quarterly risk management group meetings. Minutes showed that a standardised agenda was used to discuss topics such as the hospital culture, complaints and incidents along with performance data relating to audit results and patient outcomes. Notes were detailed and actions resulting from conversations clearly recorded.
- We reviewed the clinical governance committee minutes for June and September 2018. Standard agenda items for discussion included clinical incidents, complaints, audits and risks. The meetings were well attended by senior management, a clinical governance consultant, ward managers and ward sisters across all departments. Learning was then fed back to staff in ward and department meetings.
- The medical advisory committee (MAC), which was chaired by one of the consultants with practicing privileges, received reports from all the committees and reviewed all medical staffs practicing privileges. The MAC completed monthly sessions attended by representatives from clinical specialities and the senior management team. Meetings followed a set agenda and looked at aspects such as clinical incidents, performance monitoring, staffing arrangement, clinical developments, complaints and risks. The MAC also discussed new procedures to be undertaken to ensure they were safe, equipment was available and staff had relevant training. Information from meetings was cascaded to staff through departmental meetings. The role of the committee was to maintain the standards of work.
- Outside the MAC meetings, the MAC chair had regular contact with the senior management team. This ensured that there was a cohesive approach to care and treatment and that any issues were managed in a timely manner. Staff reported that they challenged poor practice, although confirmed that this was not a regular occurrence.
- The MAC chair told us that they sought support from clinical experts when necessary. This included support from the corporate Medical Director (MD). The MD was reported to be available always. The hospital governance structure was like the corporate structure.
- The clinical governance team and infection prevention and control committee (IPCC) received monthly infection prevention and control updates. Managers submitted these within a clinical governance report. Root cause analysis (RCA) was carried out in all cases, and included in the clinical governance report.
- Quarterly infection prevention and control reports were produced by the organisation for commissioners and the board. Exception reports were provided as required.

- The senior management team led the daily 10 at 10 communication meeting. All departments were represented for a daily update on all hospital activity, staffing and any concerns.
- Heads of department and ward meetings were held. We reviewed minutes of the heads of department meetings, ward and theatre meetings and saw that there were agenda items which included staff training, audit results, complaints, satisfaction and learning from complaints and incidents. Staff told us that they had access to the minutes from the intranet or email.
- There was a programme of internal audits used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Senior staff confirmed results were shared at relevant meetings such as clinical governance meetings. However, staff spoken with did not have any awareness of the results of audits or of any action plans to improve the service or how the results affected the service.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS) and Patient Led Assessment of the Environment (PLACE).
- The hospital had relaunched a number of local committees which included health and safety, equipment management, sustainability and the general data protection regulation (GDPR). This meant that there was greater local oversight of key issues.

**Managing risks, issues and performance**

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The hospital had a risk register which reflected risks across all services. There were 28 risks identified on the hospital risk register. These referred to clinical and financial risks such as ineffective infection control and prevention, inadequate monitoring of clinicians' competence and major development works. The service used a standardised risk calculation tool to identify risks but then processed them into three further categories:
  - Yellow- risk scores one to eight (8).
  - Orange- risk scores nine to 14 (19).
  - Red- risk scores 15 to 25 (1).
- The risk register was reviewed at each governance meeting and the medical advisory committee meetings. We saw that minutes from these meetings confirmed that risks were reviewed regularly and updated with any actions taken to mitigate them. For example, we saw that recruitment was reviewed monthly, with mitigation recorded as recruitment had been successful, resulting in a reduction in the risk score.
- Performance was reviewed by the heads of department and the senior management team. A dash board of key performance indicators was used by the service to compare their results locally and to other Ramsay providers. We saw a copy of the dash board on site during inspection, and saw that Rivers Hospital performed similarly to its peers in all categories.
- The hospital had a quality improvement plan which consisted of ten areas for improvement which included communication, leadership, training, staff engagement, environment and patient feedback. The activity was led by a designated person or team and updated regularly.
- All staff were trained to report incidents on the electronic reporting system. Staff were encouraged to report concerns, incidents and complaints. Incidents and complaints were scrutinised, fully investigated and trends monitored. Any trends identified were investigated and reported. Training needs were assessed and if individual staff competence was a concern this was addressed through human resources (HR) procedures. Any concerns relating to consultant practice were escalated to the medical director and director of clinical services.
- The local risk registers were managed by the heads of departments who escalated risks to the senior leadership team. Senior staff spoken with had a good knowledge of what was currently on their local risk register. In theatre, managers told us that slips, trips and hazardous chemicals, manual handling and staff shortages were key risks. However, staffing levels were not included on the risk register.
- Patient pathways were in place and all patients were pre-assessed by telephone for minor procedures and face to face for more complex surgery.
- The service reported externally reporting to the clinical commissioning group (CCG) and updated and published an annual quality account. Practice was audited and areas of good practice of requiring improvement identified. A monthly governance report for Ramsay Group was produced and reported on governance and quality was reported to the CCG.

- Training was implemented where training needs were identified and lessons learned sessions were delivered to ensure shared learning. For example, managers had worked collaboratively with a local patient group to develop a pathway for groups of patients refusing blood or blood products following an unexpected death.
- The hospital operated an on-call rota for all clinical areas and senior managers. This meant that staff could access senior staff for advice and support 24 hours a day.

**Managing information**

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- A range of information was available to enable manager to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances. Performance information was reviewed by the senior leadership team and actions taken to address any areas of concern.
- Nursing and medical patient records were combined within the same record. This meant that all health care professionals could follow the patient pathway clearly. We saw that staff logged off computers when they were unattended so that access was denied to unauthorised users.
- Medical and nursing records were stored in locked cupboards in locked rooms accessible only by a swipe card or keypad entry.
- Systems were in place to ensure that all external communication was sent securely.
- Information technology systems were used effectively to monitor and improve patient care. There were effective arrangements in place which ensured data such as serious incidents were submitted to external providers as required
- Staff confirmed they received information in a variety of methods which included; team meetings, newsletters, notice boards and the "WhatsApp" mobile telephone system.

**Engagement**

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- It was clear from staff comments and the overwhelming positivity of the teams that staff were fully engaged with their roles and responsibilities. Without exception, staff spoke positively about working for the hospital and were proud of what they did.
- In response to the staff survey the hospital director had devised an action plan to address the main issues raised. For example, we saw that staff had reported a lack of staff appreciation. In response the senior management team (SMT) had introduced a staff member and team of the month, a monthly staff forum, SMT drop in sessions and encouraged the heads of departments to feedback on positive contributions. The plan was to complete a repeated survey in January 2019 to identify if these actions had improved staff's feelings of appreciation.
- Staff at the hospital also provided education events for staff, patients and other health professionals, such as GPs. We saw that the education events included topics such as cosmetic surgery, hand and wrist specialities, ophthalmology, oncology and GP education. Staff told us that these events were well attended and provided links between local practitioners, patients and the hospital.
- The hospital had clinical and safety led committees that were represented by staff from all departments. There was a staff engagement group and staff forums, where staff were encouraged to feed back.
- Staff surveys were completed annually and the hospital facilitated three focus groups in August 2018. Within the focus groups, they reviewed the results, gathered further feedback from staff and put into place an action plan to improve staff experience.
- An employee innovation group had been introduced with representatives from all departments. This had been commenced following the staff engagement survey. Managers had held staff forums for all staff to attend. All teams were well represented.
- The service had links with the local NHS trust and the local hospice for dementia awareness and dementia friends training. Services and training were provided by the dementia nurses at these organisations.
- Managers had worked collaboratively with a local liaison group to develop a care pathway for a group of patients with specific needs following an unexpected death.
- Patients' views and experiences were gathered and acted on to shape and improve the services and culture.

Service user feedback was sought in various means, including the Friends and Family Test (FFT), we value your opinion feedback, "HOT Alerts" and Patient-Led Assessment of the Care Environment (PLACE) audits.

**Learning, continuous improvement and innovation**

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- Following inspection, we were provided an example of a new anaesthetic chart that was being piloted in two other Ramsay hospitals. The new chart included a detailed intra venous fluid prescription chart. Managers told us, that following approval from the clinical governance committee, the chart would be used in all Ramsay hospitals.
- Since the last inspection in June and July 2016 we found the following areas of improvement:
  - Staff training on fluid balance.
  - Aseptic non-touch technique (ANTT) and sepsis training was incorporated into mandatory training for all staff not just clinical staff.
  - Carpets had been removed from ward corridors and patient rooms to improve appearance and infection prevention and control.
  - The numbers of staff with advanced life support (ALS) training had increased.

Outstanding ☆

# Services for children and young people

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

## Are services for children and young people safe?

Good ●

Our rating of safe stayed the same. We rated it as **good.**

**Mandatory training**

- **Mandatory training in key skills was provided to all staff in children's services and systems were in place to ensure all staff were compliant.**
- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. Staff received training through the Ramsay online learning packages, face-to-face and in practical sessions. Staff in children's services were compliant with mandatory training requirements and were meeting the hospital standard of 90%.
- The Lead Paediatric Nurse (LPN) oversaw mandatory training, induction and paediatric competency based training for children's services and ensured all staff were meeting their training requirements**.**
- See additional information under this sub-heading in the surgery report section.

**Safeguarding**

- **Staff understood how to protect patients from abuse and the service worked well with other agencies. Children's services were compliant with all safeguarding training requirements.**
- Staff were able to explain safeguarding arrangements and said they would raise any queries with the children and young people safeguarding lead (LPN). Staff were aware of the hospital safeguarding policy for children and young people which was available on the hospital intranet. Staff were able to describe when they might be required to report issues to protect the safety and vulnerability of children and young people and could name the LPN. Staff told us that in their absence they would raise concerns with the matron who was the adult safeguarding lead for the hospital. Ramsay Health Care also had a safeguarding lead for the company and there was access to the clinical practice and compliance manager.
- The safeguarding lead (LPN) oversaw the delivery of safeguarding children's training and ensured staff were compliant with their safeguarding training requirements. Staff attended annual updates which were scenario based and were supported by competency training booklets which helped to demonstrate that learning had taken place and staff were both confident and competent in protecting children and young people from abuse.
- All registered nurses (child branch), the hospital matron, and clinical heads of departments and key staff directly involved with the care of CYP were trained to level 3 safeguarding children training. For example: radiographers and physiotherapists specialising in children and young people, anaesthetists, theatre and recovery staff. All staff employed by the hospital were required to undertake their safeguarding children training prior to being able to care for children and young people.
- During our inspection all relevant staff in adult areas caring for children and young people told us they had completed the appropriate level of safeguarding children training and were able to describe what would constitute a safeguarding concern. The hospital set a target of 90% for safeguarding training for level three for

children and young people and we saw evidence that the hospital was meeting the compliance target. This meant C children and young people at the hospital were protected from avoidable harm and abuse.

**Cleanliness, infection control and hygiene**

- **Infection risks were controlled well within the service.**
- At the time of the inspection all areas in children's services were seen to be visibly clean, dust and clutter free. There were no reported cases of methicillin-resistant staphylococcus aureus (MRSA), C.Diff in the previous 12 months in children and young people services.
- We noted there were hand washing facilities and hand sanitising dispensers at the exit and entry to the children's area and hand washing technique information posters were displayed above the sinks in the children and young people designated area.
- Hand hygiene audit results for children and young people services from April to November 2018 were 100% compliant with hand hygiene techniques. Staff received annual training on infection prevention and control (IPC) as part of their mandatory training. Staff were observed to be "bare below the elbow" and in line with the hospital infection control policy.
- There were cleaning schedules displayed on the children and young people area. We noted they were signed and dated to evidence regular cleaning took place. Toys in the outpatient and children and young people ward area were cleaned weekly in line with hospital policy and 'I am clean' stickers were evident on equipment which had been cleaned to confirm this.
- Personal and protective equipment (PPE) such as gloves and aprons were readily available in consulting and children and young people s rooms and were easily accessible through the use of wall dispensers.
- Clinical waste was placed into bags, labelled and secured before disposal. Waste was stored appropriately.

**Environment and equipment**

- **The service had suitable premises and equipment and looked after them well. CYP were cared for safely and were protected from potential abuse in a designated area that was secured at all times. Equipment was checked at regular intervals to ensure it was safe for use.**
- At our previous inspection, in July 2017 the physical environment of the hospital did not always ensure the safety of children and young people. Although key pads were in place on doors at either end of the corridor where children were cared for, doors were not kept locked. This meant anyone could enter the area which posed a potential risk to children and young people. This was addressed at the time of the last inspection and the doors were secured and CCTV was put in place.
- During our latest inspection, we saw children and young people were cared for in a secure environment. Following the opening of the hospital's new day surgery unit, children's services had been relocated. There were four beds for children and young people in an area designated for children. Doors to the area were secured by key pads, and entry to the area was monitored by CCTV. We saw doors to the area were secured throughout the inspection.
- Buzzers alerted staff to requests for entry to the area. Throughout the inspection we saw staff responded promptly to requests and checked the identity of people entering the area. This meant children and young people were cared for in a safe and secure environment and protected from potential abuse.
- Staff told us children and young people on the ward were either supervised by their parent or carer in the event of a parent needing to leave their child's room. Staff could be summoned (by the parent) using the call bell in the room. The nurse would then sit with the child until the parent or carer returned. Parents told us they were happy with this arrangement and felt their child was cared for safely in their absence.
- During the inspection we saw paediatric resuscitation equipment was available on the ward in day theatre and outpatients. The dedicated paediatric resuscitation trolley on the ward had age and size appropriate equipment for children and was tamper evident. There was also a paediatric resuscitation trolley next to children's recovery bay in theatres. In addition, each department had a blue lidded box which included first response equipment for an emergency with a child in the department. This ensured emergency equipment was immediately available for children and young people. Staff clearly documented daily equipment checks across all areas caring for children and young people and there were no gaps in the documented records.

- Children and young people were cared for in the day theatre recovery area. We saw reasonable adjustments had been made to make the area more child friendly.
- There were systems to maintain and service equipment as required. Equipment had undergone safety testing to ensure it was safe to use. Staff told us if there was a problem with clinical equipment for use by children and young people it was addressed immediately.
- Environmental risk assessments were undertaken daily in consulting rooms used by children and young people in outpatients and in the children's day ward. Rooms were checked for hazards, for example, window closures in place, trip hazards and securing of all cleaning fluids. This meant the risks to children and young people were being mitigated against.

**Assessing and responding to patient risk**

- **Staff completed and updated risk assessments for each CYP. They kept clear records and asked for support where necessary.**
- Children and young people were assessed as being suitable for treatment according to hospital policy before being accepted for any procedure. The LPN oversaw the pre-assessment and booking arrangements for any procedures planned for children and young people under 16 years of age. Young people aged between 16 and 17 years of age were pre-assessed and cared for as part of the adult surgical pathway unless issues were detected at pre-assessment which identified them as requiring children and young people services.
- Children's services used a Paediatric Early Warning Score (PEWS) system to alert if a child or young person's clinical condition deteriorated. Nursing staff we spoke with were aware of the appropriate actions to take if the patient's score was higher than expected. Completed PEWS charts showed staff had escalated correctly, and repeat observations were taken when required and within necessary timeframes. Audits of PEWS charts were included in children and young people documentation audits.
- Inpatient sepsis screening tool was in place for children who had a suspected infection or had clinical observations outside of normal limits. Staff told us the PEWS score would trigger the sepsis screening tool if it was required. Sepsis training was part of mandatory training and all staff in children's service were compliant and there were poster displays across the hospital.
- There were emergency procedures in the children and young people service including call bells to alert other staff and departments in the case of a deteriorating children and young people or in an emergency. The LPN coordinated emergency scenario training using child based examples. For example, a choking child. Three emergency scenarios had been held in the last 12 months. We saw where learning and feedback had been documented and shared with staff to help improve practice in a paediatric emergency. For example, paediatric oxygen masks were now attached to emergency oxygen cylinders to enable staff to respond promptly in an emergency. We saw blue masks were in place with the paediatric emergency equipment we reviewed. This meant staff were learning from incidents and had made changes to practice to improve the care of children and young people in an emergency.
- The service had access to a resident medical officer (RMO) who was trained in advance paediatric life support (APLS). The RMO provided support to the CYP service if a children and young people became unwell. Patients who became unwell were transferred using the children's acute transport service (CATS) service to a local NHS acute trust in line with the emergency transfer policy.
- In the last 12 months there were no children who had become unwell following their admission to day surgery.
- The anaesthetic consultant remained in the hospital until the children and young people was discharged from recovery and had been reviewed on the ward.

**Nurse staffing**

- **The service had sufficient staff with the right qualifications, skills, training and experience.**
- During our last inspection there was no dedicated registered nurse (child branch) in the outpatient department. During our inspection we saw the service now employed two full time equivalent (FTE) registered nurses (child branch) on the ward and in the outpatient department. This meant all children under the age of 16 years received direct care from registered nurses (child branch) across all children's services at the hospital.
- The LPN (FTE) planned all children and young people admissions to ensure the ward, the pre-assessment clinic and children and young people's outpatients was staffed appropriately. At the time of the inspection there were two FTE registered nurses (child branch) on the

ward and in the outpatient department. This meant the service was meeting the Royal College of Nursing guidance on 'Defining staffing levels for children and young people's services' (2013) which states, for dedicated children's wards there is a minimum of 70%: 30% registered (child branch) to unregistered staff with a higher proportion of registered nurses (child branch). The service was staffed above the minimum requirements.

- Children's service deployed regular bank nurses who were registered nurses (child branch) and who were well known to the service and children and young people. All bank staff were required to complete mandatory training updates which included safeguarding children and paediatric competencies. This meant there was continuity of care for children and young people attending outpatient services by staff who were competent to undertake their roles.
- The guidance also states for children and young people day theatre services, one registered nurse (child branch) must hold a valid APLS qualification. The service was meeting this requirement.

**Medical staffing**

- **The service had sufficient medical staff with the right qualifications, skills training and experience.**
- There were six paediatricians who had been granted practising privileges at the hospital who were able to treat children and young people. Paediatric clinics were run six days a week and the paediatricians were also available to be called upon in the event of an unwell child. Practising privileges is a term used when doctors have been granted the right to practice at an independent hospital. All the paediatricians cared for children and young people at other NHS trusts in the area.
- Anaesthetists that were trained to anaesthetise children and young people had been granted practising privileges at the hospital. They were part of the anaesthetic group from the local trust which provided a weekly rota to cover theatres, supported pre-assessment and provided an out of hours on-call rota for the hospital. Anaesthetists that anaesthetised children and young people had completed the appropriate level of training in APLS/EPLS (advanced paediatric life support or European paediatric life support. The hospital ensured there were always two people in theatre, the ward or in clinic trained in advanced life support for paediatrics. This meant there were sufficient staff who were trained to the appropriate level to meet the needs of children and young people whose clinical condition had deteriorated.
- Consultant (paediatricians) caring for children and young people were required to provide documentary evidence of safeguarding children level three training and evidence of treating children and young people in their practice in the NHS. We saw this recorded in the minutes of the medical advisory committee (MAC) which had a paediatrician representative on the committee.
- The hospital always had a resident medical officer (RMO) on duty who was part of a rota of four RMOs who were trained in APLS and safeguarding children level three training.

**Records**

- **Staff kept detailed records of patient's care and treatment and individual records were managed in a way that kept patient's safe.**
- Patient records contained information of the patient's journey through the service including investigations, test results, and treatment and care provided. Patient's records were paper based, except for digital images of x-rays and ultrasounds. All the records we saw (seven) were accurate, complete, legible and up-to-date and were stored securely.
- We reviewed seven sets of patient records. Information was easy to access and the information contained information about the patient's journey through the hospital including pre-assessment, investigations, results and treatment provided. Theatre records included the five steps to safer surgery checklist. We saw these were completed fully and appropriately.
- Discharge letters were sent to GPs immediately after discharge, with details of the treatment, including follow up care and medication provided.

**Medicines**

- **Staff prescribed, gave and recorded medicines well. Patients received the right medication and the right dose at the right time.**
- Medicines were kept securely in the children and young people service. They were stored in locked wall cupboards in a locked room.
- Children's weight and allergies were recorded on all medication charts we reviewed.

- Parents were given a 'discharge medication information' leaflet prior to their children and young people being discharged from the hospital. The leaflet requested parent to discuss their child's needs with the nurse (child branch) in relation to pain management and who to contact if they had any concerns about their child's pain or medication.
- Treatment room and fridge temperatures were checked and recorded daily in the children and young people service to ensure medicines were kept at the correct temperature. Staff understood the procedures to follow if temperatures were not correct.
- Blank NHS private prescription pads were stored securely in the outpatient department and a system was in place to ensure they were managed appropriately. We were told that as there were extended pharmacy opening hours, they were not used very often.
- **For our detailed findings on medicines please see the Safe section in the surgery report.**

**Incidents**

- **Staff recognised incidents and reported them appropriately. Managers investigated incidents and provided feedback to staff.**
- During our inspection we observed that staff understood their responsibilities to report incidents and children and young people and their parents were informed when things went wrong. Incidents were reported and investigated and were subject to high quality review by the LPN and the matron. For example, following an investigation into a child who had acquired an infection following a circumcision, the Ramsay clinical lead for infection prevention and control recommended the skin preparation for patients undergoing circumcision to be changed. We saw that theatres had been advised and the consultants had changed their practice. This demonstrated that there was learning from incidents to help improve the care of children and young people.
- The hospital did not report any 'never events' in children and young people services between August 2017 and July 2018. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all health care providers.
- Staff in children's services were confident in the use of the electronic incident reporting system used to report incidents at the hospital and told us they always reported incidents. The LPN told us feedback from incidents was shared with staff in children's services and there was evidence of decisions and discussions at team meetings to support learning and changes to practice when they were required.
- Staff could describe the principle and application 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. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened. We spoke to the LPN who gave us an example of duty of candour following an incident they were involved in. They explained how they had contacted the parents of the patient, explained what had happened and apologised.

**Safety Thermometer (or equivalent)**

- **The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.**
- Children's services showed there were no reports of MRSA, E-Coli or C. Diff during the reporting period.
- **See information under this sub-heading in the surgery report.**

## Are services for children and young people effective?

Good

Our rating of effective improved. We rated it as **good.**

**Evidence-based care and treatment**

- **Care and treatment was provided based on national guidance and evidence of its effectiveness. Managers assessed staff compliance with guidance and identified areas for improvement.**

- The service provided care and treatment based on national guidance and evidence of its effectiveness. The National Institute for Health and Care Excellence (NICE) guidelines were routinely discussed and reviewed at clinical governance and heads of department and team meetings. The lead paediatric nurse (LPN) told us that NICE guidance was followed for the pre-assessment of children and young people prior to surgical day case procedures.
- The hospital had policies for the care of children and young people which were in line with the Department of Health's guidance on the National Service Framework for Children. This meant the hospital had taken steps to ensure children and young people were cared for in line with best practice. For example, Royal College of Nursing (RCN) on staffing and the use of Gillick and Fraser competence. These are terms that are used to assess whether a child (16 years or younger) was able to consent to their own medical treatment.
- Anaesthetists undertaking procedures on children worked within the Royal College of Anaesthetists "Guidance on the Provision of Paediatric Anaesthesia Services", 2013.
- Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief or sexual orientation or age. Staff in children's services had a good understanding of and had read local policies and were able to access them using the hospital intranet.
- The hospital had a chaperone policy, which followed NHS, General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance. Staff were aware and followed the policy. For example, when children were transferred to or from the operating theatre they were always accompanied by a registered nurse (child branch).
- At our previous inspection the hospital did not have an audit programme that was specific to the needs of children's and young people's services. This meant that care was not monitored to demonstrate the compliance with best practice guidance. During this inspection we saw children and young people services were involved in a hospital wide programme of annual and weekly audits. For example, hand hygiene, patient equipment, medicines, environment, pain management and documentation audits. Staff were aware of the results for their area and could tell us about the measures the service had undertaken to improve compliance. We saw evidence of results on display to inform staff of the service's performance.

**Nutrition and hydration**

- **Staff gave children and young people enough food and drink to meet their needs and improve their health.**
- Children's and young people's nutrition and hydration needs were assessed at pre-assessment and documented on their care record. Where children and young people had specific dietary requirements, appropriate arrangements were put in place. For example, a child who was a vegetarian was able to choose a vegetarian meal.
- Parents told us they rated the food for their children as being ten out of ten. Children said, "I really enjoyed the food and could choose what I wanted to eat". The hospital provided suitable meals and drinks for children and young people and alternative menus were available for children to choose from to encourage them to eat and drink normally. These included foods to appeal to younger children such as finger food, ice cream and yogurts.
- Parents told us there was a good selection of appropriate foods available for their child who was able to choose what they wanted to eat.
- A dietician with practising privileges was available to see children and young people who were identified at pre-assessment as having issues with nutrition and hydration.

**Pain relief**

- **Pain assessments were embedded into the paediatric pathway.** Nurses used the Wong-Baker 'smiley faces' pain rating tool where children were asked to choose the face that best described how comfortable or uncomfortable they were feeling. We reviewed seven sets of records and all had completed pain assessments.
- Pain was monitored from surgery through to discharge. Both the consultant surgeon and anaesthetist were available in the hospital until children and young people had left recovery should there be any issues with pain prior to discharge.
- Parents we spoke with told us their child's pain had been well managed and medicine records showed prescribing of pain relief.

- The LPN told us registered nurses (child branch) would assess a child's pain in recovery ensuring it was well managed before taking the child back to the ward and we saw evidence of this during the inspection.
- The service undertook monthly pain audits for children and young people. In the period April to November 2018 audit compliance was 100%. This meant children and young people s pain was consistently managed well and children were pain free following surgery.

**Patient outcomes**

- **The effectiveness of care and treatment was monitored and findings consistently used to improve outcomes.**
- There were no national audits undertaken by the hospital involving children and young people. Changes to practice were implemented to improve patient outcomes for children and young people. For example, all children and young people attended a face-to-face pre-assessment clinic to assess their suitability for surgical intervention.
- At our previous inspection information about the outcomes of children and young people care and treatment were not routinely collected and monitored. As the service did not have a robust system for monitoring the outcomes for patients we were not assured the service could drive improvements due to the lack of monitoring and performance information. During our inspection we saw children's services were incorporated into the overarching audit tool for the hospital. Ten sets of records were reviewed each month and identified good patient outcomes for children and young people. For example, pre-assessment and discharge checks, completion of risk assessment tools and consent. This meant the service was able to demonstrate good outcomes in the quality of care being delivered to children and young people.
- The service assessed the quality of care for children and young people using patient reported outcome measures (PROMS) which assesses the quality of care from the patient's perspective. PROMS enabled services to calculate the health gains for patients after surgical treatments using pre- and post-operative surveys. PROMS were implemented for children and young people in 2018 for patients having the three most common procedures of; tonsillectomy, circumcision and insertion of grommets. The PROMS outcomes were compared with other hospitals' data in the Ramsay group and national data.
- The PROMS outcomes for the period April to November 2018, reported that the overall health gains for the three common procedures were excellent overall. There was one reported case of infection following a circumcision involving a child. The service had completed incident forms and an investigation had been undertaken. The Ramsay lead for infection prevention and control had identified that following the investigation, there was a need to change the skin preparation that was used for patients undergoing circumcision. We saw that theatres had been advised and consultants had adopted the change in practice.

**Competent staff**

- **There were measures in place to ensure staff were competent for their roles.**
- The service ensured staff were competent in their roles and we saw evidence that all staff I children's services had received an annual appraisal to support their clinical development. Recently appointed staff in children's services had attended induction training which included a corporate and local induction and a local orientation.
- The LPN was qualified in European paediatric advanced life support and was supported by a named consultant paediatrician. There were six other consultant paediatricians with practising privileges if additional support was required.
- The LPN oversaw the training and development of staff in children's services and ensured mandatory training, safeguarding children level three and paediatric competency booklets were completed within the agreed timescales. Staff we spoke with confirmed they had completed their mandatory training and competency assessments and told us they were given time to complete electronic learning. Staff told us development opportunities were identified at appraisal and they were supported by the LPN in their requests for additional training at other times as required.
- Each child or young person were cared for by a registered nurse (child branch) who was accountable for the child's entire care pathway. Nurses were involved in the planning, delivery and oversight of each child's care

and were trained in European paediatric life support (EPLS). The resident medical officer (RMO, one of four) was always on duty and able to support a sick child and was trained in advanced paediatric life support (APLS). All anaesthetists were either APLS or EPLS trained and there was always a minimum of two people available in outpatients, on the ward and in theatres who were trained in APLS. This meant there were sufficient staff who were trained appropriately to care for children whose condition had deteriorated. Nurses were also trained in the use of the WETFLAG (paediatric resuscitation) approach to the care of sick children whose condition had suddenly deteriorated. Which meant they had additional skills to help identify when children became suddenly unwell.

- Consultant surgeons at the hospital had practising privileges and scope of practice to undertake surgery on children and young people, and all conducted the same operations in their NHS practice. Anaesthetists at the hospital were also used in the NHS. This meant that surgeons and anaesthetists routinely undertook surgery and anaesthesia on children and young people as part of their usual practice.

**Multidisciplinary working**

- **Staff worked together as a team to benefit patients.**
- There was a strong multi-disciplinary (MDT) approach across all areas we visited. Staff in children's services of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. Staff reported good multi-disciplinary working with access to medical and physiotherapy staff. Medical staff told us there was a very good team approach to caring for children and young people and were said they were pleased about the appointment of additional registered nurses (child branch) to the outpatient department. We were told that the increase in workload around the needs of children and young people with ear, nose and throat (ENT) conditions was likely to mean children's services would be further developed.
- Throughout our inspection we were told how the LPN had developed strong multidisciplinary relations with consultants, heads of departments, senior managers and administrative and support staff. Staff felt able to raise issues and concerns about children and young people services and had welcomes the opportunity to learn more about the care and support for children and young people at the hospital.
- The LPN worked with all staff that cared for children and young people across the hospital. Staff told us there was now a coordinated approach to pre-assessment and booking of children and young people attending the hospital.
- The named consultant paediatrician was the paediatric representative on the Medical Advisory Committee which meant there was children and young people representation which supported the development of children and young people services.
- We saw in patients records that GPs were kept informed of treatments provided; follow up appointments and medications to take on discharge.

**Seven-day services**

- **Resident Medical Officers (RMO'S) provided a 24 hour a day, seven days a week service on a rotational basis.** The RMO's were paediatric resuscitation trained and had undertaken level three safeguarding training.
- Parents could access clinics out of working hours. For example, pre-assessment clinics were held on Sundays and children and young people outpatient clinics were held on week day evenings to enable parents to attend after work and school.
- Children had access to radiology, pathology and physiotherapy services six days a week if required.

**Health promotion**

- **Staff supported patients to manage their own health, care and well-being as appropriate.**
- **See information under this sub-heading in the surgery report section.**

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- **Staff understood how and when to assess whether a** children and young people **had the capacity to make decisions about their care. They followed hospital policy and procedures when a patient could not give consent.**
- We looked at seven patient's records and saw consent forms were fully completed, signed and dated by the

consultant and patient/parent. The planned procedure was identified, the associated risks, benefits and intent of treatment was described and the patient had been assessed as having capacity for treatment.

- The hospital's consent policy for the examination and treatment of children and young people was available in the hospital intranet for staff to view. This included information to guide staff on consent issues such as where a parent was unable to consent on behalf of a child due to a lack of mental capacity and gaining consent from a young person as well as their parents.
- Staff we spoke with had an effective understanding of gaining consent from children and young people and guidance around this with regard to capacity to consent, including Gillick and Fraser competence. Gillick and Fraser competency is used to help decide whether a child or young person was mature enough to make their own decisions and helps to balance the rights of the hospital's responsibilities to keep children and young people safe from harm. Gillick competence is concerned with determining a child or young person's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and guidance.
- The hospital's consent to treatment policy (2018) described how young people under the age of 16 years, might be considered Gillick competent to consent to treatment. This meant that children who have sufficient understanding to enable them to understand fully what was involved in a proposed intervention would have the capacity to consent to the intervention.
- We saw all grades of staff seeking appropriate consent from patients and relatives (where required) before undertaking an intervention. Nursing staff gained verbal consent before undertaking interventions such as clinical observations or giving medication.
- Mandatory e-learning training about safeguarding provided for staff included information about the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Training compliance for the children and young people service was 100%.
- Children's services undertook monthly consent audits which included reviewing compliance with Gillick and Fraser competencies. In the period April to November 2018 consent audits reported 100% compliance. This meant children and young people were being consented appropriately for treatment and interventions and had been assessed as having capacity to undergo treatment.

## Are services for children and young people caring?

Outstanding ☆

Our rating of caring improved.We rated it as **outstanding**.

**Compassionate care**

- **Feedback from people who used the service and those who were close to them were continually positive about the way staff treated people. People said that staff went the extra mile and their care and support exceeded expectation. Parents and children attending day surgery rated the service as ten out of ten.**
- Children and their relatives told us how happy they were with care throughout the hospital. They said staff were always "very caring" and went the extra mile to ensure their child experienced the best possible care during their hospital stay.
- We spoke to six parents and two children who had recently been admitted to the hospital for a day surgery procedure. The first child told us "It was a great experience and everyone at the hospital was wonderful and I was very well cared for". The second child said, "The nurses and doctors were so kind and really looked after me". All of the parents and children rated their day surgery experience at the hospital as being ten out of ten.
- The parents of a child undergoing a repeat day surgery procedure, told us they had been able to accompany their child to the anaesthetic room which was not the usual hospital policy, and had stayed with them until they were asleep. The nurses and anaesthetist were aware that the child was very nervous about their repeated procedure and had tried to minimise any distress to the child. This meant the child and their family were cared for with kindness and compassion. The parents also praised the staff as their needs had also been accommodated as a nurse had taken them to the restaurant while their child was asleep as they had

been unable to eat due to their child being 'nil by mouth'. The child and their family told us the service 'was amazing' and would recommend the hospital to their family and friends.

- Another family whose older child was having a dental extraction, told us the anaesthetist had spent time supporting their child to help them to understand how the anaesthetic could be administered without the use of a needle as they were very frightened of them. The anaesthetist was able to offer their child an alternative to an injection which was appreciated by the child and provided reassurance to the family that their child was being treated as an individual.
- Staff were friendly, professional and compassionate and helpful to children and their parents and families. Parents and children told us they were very happy with the care and support they received throughout the children's services. A parent said, "staff were always very kind to their child and spent as much time as was needed to explain what was going to happen to them". Another parent said, "My child had recently been diagnosed with a long term medical condition and the consultant was so kind to them and talked to them throughout their outpatient appointment in a language my child could understand and answered all their questions".
- Children (who wanted them) were given a Rivers teddy bear when they were admitted for day surgery. The teddy bear would be placed on the bed for younger children to welcome them to the ward.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction and asks people to identify if they would recommend the service to their friends and family. In the period April to November 2018, children's services scored between 98% and 100% from parents who would be 'highly likely' to recommend the service to their friends and family. Parents said, "friendly and empathetic staff in a child friendly environment', and 'always very professional and caring which made my child's first visit to a hospital as friendly and positive an experience as it could be".
- The parents of a child who had undergone day surgery during our inspection told us how kind and patient the nurses were and how they understood from their child's perspective how frightening an operation could be, particularly the anaesthetic. Response rates for the FFT were above 60% which was above the national average which meant the FFT test results were representative of people's views which was an improvement from our previous inspection.
- Feedback in patient surveys rated children's services as being between 95% and 100% for all aspects of care including the overall rating for care 100%, being looked after 100% and the care of nurses doctors and physiotherapists was rated between 94% and 100%.
- Children were able to complete their own feedback forms and at the time of the inspection all the comments we reviewed were positive. For example, 'thank you for looking after me so well', and 'the food was lovely', and 'I really liked the toys and videos I played with', and 'the magic cream made the pain go away'.
- Parents had also suggested a wider provision of toys and colouring materials and we saw there was an increased provision of diversional activities suitable for all ages than was available at our previous inspection. The service had also invested in staff training through attendance on children's play programmes to enable staff to better interact with children and help to minimise any undue distress.

**Emotional support**

- **People who used the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person.**
- We saw evidence of this during our inspection. For example, a child who had undergone a day surgery procedure, was supported by the nurse caring for them on their return from theatre by ensuring they were not experiencing any pain and provided reassurance to the child and their parents about how to care for the dressing and who to contact if their child became unwell following their discharge home.
- Staff involved with the care and support of children understood the need for emotional support for parents and their families. We spoke with children and their families who told us staff cared for their emotional wellbeing.
- Staff were able to build relationships very quickly with children and young people and their parents and families. For example, in day theatre where staff were able to support the child and parent and ensured they both understood the procedure.

# Services for children and young people

- Children and young people attending pre-assessment were shown the type of equipment that would be used when they were admitted to the hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had the equipment demonstrated on toys and were able to familiarise themselves by playing with the equipment. Children were told the cannulas would not hurt as local anaesthetic cream (magic cream) would be applied in advance. Feedback from children praised the magic cream and reported 'they had not felt any pain at all when the needle went into their hand'.
- Children and young people requiring day surgery were accompanied by a parent to day theatre. This ensured parents were able to continue to provide emotional support for their child. Parents were able to see their children in the recovery area as soon as they were awake to provide reassurance and support.

**Understanding and involvement of patients and those close to them**

- **People valued their relationships with the staff team and felt they went "the extra mile" for them when providing care and support. People felt really cared for and that they mattered.**
- Children and parents were actively involved in care and treatment and their views were considered when planning care. This was evident throughout the departments attended by children for example, the children's ward, X ray, outpatients and the physiotherapy department where older children were given the opportunity to speak to clinicians without their parents being present. A young person told us they were asked questions by the doctor and nurse at their outpatient appointment and were encouraged to answer for themselves although their parents were present.
- Children and their parents we spoke with felt well informed about their care and treatment were kept informed of changes to their child's care by the multidisciplinary team. For example, parents told us the doctors (consultant surgeon and anaesthetist) had come to tell them what had happened during their child's surgery.
- All parents we spoke with told us how they were fully involved in the assessment, planning and delivery of care and support to their child throughout the hospital experience. Parents attending the pre-assessment service praised the nurses on how they felt engaged with their child during the pre-assessment process. Nurses addressed the fears and concerns of each child (where appropriate) so children knew what was going to happen to them. For example, a child told us what was going to happen to them on their day of surgery. And what would happen when then were discharged home.
- Children and young people attending for day surgery received comprehensive information in a clear and simple format before admission. It detailed what they should expect at their (child's) admission and the facilities that were available for them to use. It also included information about their hospital stay and discharge arrangements. Information about anaesthesia was available for children of all ages and was presented in age appropriate formats.
- All children attending for day surgery had attended a pre-assessment clinic which had included a visit to the ward, anaesthetic room and theatre. They were also shown the type of equipment that would be used, for example syringes and blood pressure monitors (toy versions) and were able to familiarise themselves with them prior to surgery.
- Younger children were shown the type of equipment that would be used. For example, cannulas, syringes and blood pressure cuffs. Nurses demonstrated on toys how the equipment would be used and children were able to familiarise themselves with the equipment through play. Child and parents told us how helpful the approach was and had helped to minimise their child's fear and anxiety about their forthcoming admission.

## Are services for children and young people responsive?

Outstanding ☆

Our rating of responsive improved. We rated it as **outstanding.**

**Service delivery to meet the needs of local people**

- **People's individual needs and preferences were central to the delivery of tailored services. The service was flexible and provided informed choice and ensured continuity of care.**
- During our last inspection, children and young people services were not always responsive to the needs of patients and were rated as requires improvement. There

was a lack of recognition of children's services as a separate, distinct service in the hospital. During this inspection, we saw the service provided reflected the needs of the population they served and ensured flexibility, choice and continuity of care.

- Children and young people accessed the following services in the hospital: outpatients, pre-assessment, radiology and diagnostic imaging, the day case ward for day cases, theatres and physiotherapy. Occasionally, a patient required a one or two-night stay for a specific procedure. We were told this happened once or twice a year and was planned to ensure appropriate registered nurses (child branch) were rostered to care for the child or young person.
- During our last inspection, children and young people shared the same environment as adult patients in all areas of the hospital. There was no dedicated registered nurse (child branch) in the outpatient department and in the event of a patient in the outpatient department requiring additional nursing support, the registered nurse (child branch) would be called to assist leaving the ward uncovered.
- During our inspection, we saw children's services were now allocated on Meadow ward. Four beds were planned for the sole use of children and young people and were protected by security doors key pads and buzzers. Although the rooms had not been specifically designed to be used by children, the service was continuing to create a child friendly environment. Age appropriate bed linen was in place and there were colourful pictures on the walls which had been chosen by children attending the hospital. A mural was planned for the area and staff were very keen to be involved in future developments. The LPN had created a children's play trolley which was supplied with a wide variety of colouring materials, toys and DVDs. Plans were in place to further expand the play facilities in the ward and in outpatients. Younger children were encouraged to bring their favourite toys with them on admission to hospital and older children and young people were able to access to WI FI to enable them to use their mobile phones and tablets.
- All children and young people referred to the service were overseen by the LPN and the booking team to ensure all aspects of care and treatment were assessed and considered prior to a children and young people being booked onto a surgical list or into an outpatient clinic.
- The service did not undertake acute or emergency surgical admissions for children and young people and all patients were privately funded. All surgical interventions were undertaken as day cases. The hospital had no critical care facilities and children and young people were screened at pre-assessment to ensure the hospital had suitable facilities to treat them. A service level agreement was in place with the children's acute transport service (CATS), if the condition of a children and young people deteriorated and they required an urgent transfer to an NHS acute hospital.
- Children and young people attending day surgery received comprehensive and age appropriate information in a clear and simple format prior to admission. It detailed what they should expect at their admission and facilities available for them to use. It also included information about anaesthesia and their hospital stay and discharge arrangements.
- Facilities were available for parents and families in the outpatient department. Parents were able to access a vending machine for drinks and snacks in the outpatient area and toilets and nappy changing facilities were available. Staff told us parents would be allocated an appropriate area for breast feeding if it was required.
- Staff said the hospital worked closely with other paediatric health services. For example, GPs and health visitors.
- Physiotherapy services provided treatment and support to children and young people experiencing for child development issues, sports injuries and orthopaedic conditions. Physiotherapy treatments were available in the evenings to enable children and young people not to miss their schooling. The service was staffed by experienced physiotherapists some of whom were trained and experienced in the care and treatment of children and young people. Approximately 10% of the physiotherapy case load was dedicated to children and young people's services. All staff were trained in level three safeguarding children training and had attended intermediate life support (ILS) to support the care of children and young people requiring emergency treatment.

**Meeting people's individual needs**

- **There was a proactive approach to understanding the needs and preferences of children, young people and their parents and families in ways that were accessible and promoted equality.**

# Services for children and young people

- The individual needs of children and young people were assessed by the LPN and the paediatric team. Children with complex needs were supported by staff to access the hospital facilities. For example, access for patients who were in a wheelchair or with a learning disability. This was to ensure the safety and wellbeing of patients.
- All children and young people were pre-assessed prior to surgery which was in line with hospital policy. The LPN coordinated pre-assessment clinics which were held on a Sunday and children of all ages visited the day theatre and recovery areas to help familiarise themselves with the hospital prior to their admission.
- The service had strict admission criteria and did not admit children and young people with complex co-morbidities. We reviewed six sets of patient records and all patients had a completed pre-assessment checklist. Parents and children and young people told us they were given detailed explanations about their admission and treatment. Parents said age appropriate language was used by the doctors (consultants) and nurses to explain procedures to their child and pictures and toys were used to help in explanations to younger children. In addition, information leaflets for a wide range of conditions and to support the care given were available. These were written in English but could be obtained in other languages.
- All children and young people and their parents received a follow up telephone call within 48 hours of discharge. In the six sets of patient records we reviewed we saw the telephone call had been documented. We also held telephone interviews with five parents and two young people who all told us how much they appreciated the telephone call and how reassuring it was to talk to the doctor (consultant surgeon) and the nurse.
- Parents spoke highly about the support they received from the hospital and praised all the departments including the ward, physiotherapy outpatients and the doctors (consultants).
- The service provided appropriate translation services, hearing assistance, sign language interpreters or other assistance to ensure the individual needs of children and young people were considered.
- Children and young people with special needs were treated in quieter areas of the physiotherapy department and sessions were planned to cause the minimum of disruption to the child or young person's daily routine. Physiotherapists worked closely with the LPN and the registered nurses (child branch) in outpatients and told us how well the services worked together. The lead physiotherapist told us how the profile of children and young people services had been raised by the LPN and how positive staff were in the (physiotherapy) department around their involvement in children's training.
- Parents were provided with a letter for the school nurse following their child's surgery for circumcision. The letter explained that the child would require a week off school and therefore the absence would not be counted as an 'unauthorised attendance'.
- Parents were given an appointment card at their child's outpatient appointment with contact details should they require them before their child's next appointment

**Access and flow**

- **People were able to access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure people had timely access to treatment, support and care.**
- Processes were organised for care and treatment to be provided by the hospital in a timely way. General paediatric outpatient care assessed children from zero to 18 years of age with symptoms across the general paediatric spectrum. For example, ear nose and throat (ENT), urology and general surgery. Occasionally a child was admitted for an orthopaedic procedure. We were told by the LPN this was always planned and managed by the paediatric multi-disciplinary team. There had been two orthopaedic admissions in the last 12 months.
- Treatments were offered to children and young people from the ages of three to 18 years unless they were assessed and treated on the adult pathway (between the ages of 16 and 18 years) by the paediatric team.
- Day theatre lists for children and young people were planned by the LPN, the theatre manager and the booking team for a maximum of four children and young people. All children under the age of 16 years received direct care from a registered nurse (child branch). Theatre lists for children and young people were held two days a week and were run early in the morning to enable children and young people to recover and go home the same day. If a child requires a longer period of recovery a late discharge or overnight stay was arranged in conjunction with the LPN and the consultant paediatrician.

# Services for children and young people

- All operating dates were published in advance to ensure the safe planning of children and young people surgical lists. This ensured the hospital was compliant with the Royal College of Nursing guidance and standards which state a minimum of two registered children's nurses should be on duty throughout the time children are cared for.
- Patients had timely access to initial assessment and treatment through a private paediatric referral pathway at the hospital. The booking system was conducive to meeting patient's needs. Patient's/parents could select times and dates for appointments to suit their child's school commitments or the child's family. Appointments could be before or after school and between school terms. A parent told us they had contacted the hospital the day before and had been able to arrange an appointment. Another parent told us "The first appointment my child was given was not convenient so I spoke to the receptionist who accommodated my child's needs and made the appointment at the end of the school day".
- Parents told us throughout the inspection there were minimal waits to get an appointment for outpatient clinics. If there were delays on arrival parents and young people were notified. We observed there were no waits throughout the inspection.
- In the reporting period August 2017 to July 2018, there were; 544 outpatient attendances for infants aged zero to two years, 2,342 outpatient attendances for children aged three to 15 years and 698 outpatient attendances for young people aged 16 to 17 years. There were 231-day case procedures for children aged three to 15 years and 698-day case procedures for young people aged 16 to 17 years.
- The LPN told us if a child did not attend (failed to be brought) for an outpatient appointment they would be advised and contact would be made with the child's parent to identify the reason for a non-attendance. If concerns were identified or it was not possible to contact the parent by telephone a letter would be sent to the parent and copied to the GP and health visitor. When procedures had to be cancelled or were delayed, this was recorded as a clinical incident and appropriate actions taken. Cancellations were rescheduled as soon as possible in discussion with the LPN and the paediatric team, the children and young people and their family.
- The physiotherapy lead told us they supported the care of children and young people and received referrals from consultants. The LPN liaised with the service following children and young people pre-assessment to ensure appropriate equipment was made available following surgery.

**Learning from complaints and concerns**

- **The service could demonstrate where improvements had been made as a result of learning from complaints and learning was shared with other service in the hospital.**
- The hospital had a clear process for dealing with complaints. There was a complaints policy in place and staff we spoke to in children's services were aware of the complaints procedure. There were no complaints referring to children and young people.
- We saw information on how to make a complaint in areas where children and young people were cared for in the hospital. If a child, young person or parent wanted to make a complaint they would be directed to the LPN or senior staff member. Patients/ parents would be advised to make a formal complaint if their concerns could not be resolved informally.
- Lessons learnt from complaints were discussed in departmental meetings to offer staff an opportunity to reflect on the complaint and discuss where improvements could be made. Parents we spoke with told us they did not have any reason to complain about children's services but felt confident in raising a concern or complaint if necessary.
- The ward had a 'How did we do' board and we saw examples of where children and parents had made suggestions on how services could be improved. For example, the strength of the WIFI signal in certain parts of the hospital was poor so the children's service had purchased equipment to boost the signal. This meant older children were able to use their mobile phones and electronic tablets s when visiting the hospital.

Outstanding ☆

# Services for children and young people

## Are services for children and young people well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as **outstanding.**

### Leadership

- **There was compassionate, inclusive and effective leadership of children and young people's services. The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**
- At our previous inspection, children's services were rated as 'requiring improvement' with regards to being well-led. There was no one person with clear responsibility for leading the service for children and young people. At this inspection, children's services were led by a full time equivalent (FTE) lead paediatric nurse (LPN) who planned for and oversaw the care of children and young people in all departments of the hospital. The LPD was based on Meadow ward which had four dedicated beds that was designed and age appropriate for children and young people.
- The service had continued to review and improve children and young people services and had recognised since our previous inspection, the need for increased access to the service in the local community. Additional paediatric trained staff had been recruited to support the patient journey throughout the hospital and staff were undergoing training in play therapy courses to improve their engagement with children and young people.
- Nurses, consultants, heads of services and support staff told us the LPN had raised the profile of children's services and was recognised as being the clinical expert in matters relating to children and young people in the hospital. Staff told us the LPN visited areas where children were treated daily and oversaw all paediatric admissions to the hospital. All staff told us the LPN was visible and accessible in the hospital should they require advice and support in relation to any children and young people undergoing treatment. At department level staff in children's services reported to the LPN who reported to the hospital matron. All staff felt they could be open with colleagues and managers and were able to raise concerns and felt they would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.

### Vision and strategy

- **There was a systematic and integrated approach to monitoring, reviewing and providing evidence of the progress of children and young people's services in line with the hospital vision and strategy.**
- The hospital had a strategy whose values aimed to put "people at the HEART of all we do". The hospital had incorporated the six clinical core values (6Cs) which were: commitment, courage, communication, care, compassions and competence.
- Staff in children's services were aware of the vision and strategy and were able to refer to it directly. Although there was no dedicated strategy for children's services, plans for the development of children and young people on the hospital's journey to outstanding, made reference to the development children's services. For example, children and young people safeguarding systems and processes and ensuring the security of children on the ward.
- **See information under this sub-heading in the surgery report section.**

### Culture

- **Staff in children's services were proud of the organisation as a place to work and spoke highly of the child-centred culture that was evident across the hospital.**
- Staff spoke positively about working in children's services and described a culture that was open and friendly with an emphasis on delivering high quality care to children and young people. We saw that the culture of all areas we visited during our inspection centred on the needs and experiences of children and young people and their families. For example, if a mistake happened this was handled in a sensitive and open way. The LPN and named paediatric consultant promoted a culture of 'child centred' care and staff across the hospital told us they were proud to be involved in promoting the needs of children and would recommend the service to their own family and friends.

- Lead clinicians in physiotherapy, outpatients and imaging services spoke positively about the drive by the LPN to ensure all staff who cared for children across the hospital were trained to the highest standard. For example, all staff completed level three safeguarding children training which included annual updates and the completion of core safeguarding competencies. This meant the culture around the care of children was more 'child centred' and children's services were now seen as being a distinct service and was separate from adult services. This was an improvement from our previous inspection where children's services had not been recognised as being a service in their own right.

**Governance**

- **Governance arrangements in children's services were proactively reviewed and reflected best practice. A systematic approach was used to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- During our previous inspection, the risks to children and young people using the service had not been recognised, assessed or mitigated against before our inspection. However, issues with regards to safety and access of children and young people had been addressed before the end of our inspection. During our inspection we saw children and young people were cared for in safe and secure environments and access was controlled using key pads. This meant the hospital had responded appropriately by risk assessing the area and implementing mitigating actions to reduce the risk.
- The hospital employed registered nurses (child branch) to oversee the care of children and young people who were seen as an outpatient or admitted for surgery. The LPN monitored the training of staff who were required to complete safeguarding level three training and paediatric competencies to enable them to care safely for children attending the hospital. The matron included this information in monthly children and young people governance reports.
- At our previous inspection, although governance arrangements were in place, not all significant concerns such as security had been discussed at clinical governance meetings and the service was not collecting any outcome measures for children and young people. This meant we were not assured the service was using any outcome and performance measures to drive improvements. During our inspection we saw the service had clear governance systems in place and held meetings through which governance issues were addressed. The meetings included the medical advisory committee (MAC), heads of department meetings, quarterly governance meetings and team meetings. All meetings had representation from the LPN or the named paediatric consultant and were attended by members of the multi-disciplinary team who oversaw children's services. Minutes of meetings recorded discussions on staff training, incidents, complaints, and a review of children and young people patient clinical outcomes and feedback from patients, parents and their families. Children's services were audited in line with the hospitals governance policy. For example, patient documentation, infection control and pain management audits to ensure continuous monitoring and enhancement of the quality of care delivered to children and young people.
- Governance meetings also reviewed how improvements to children's services could be made. For example, the service monitoring patient outcomes through patient related outcomes measures (PROMS) for tonsils, grommets and circumcision. This included documenting any concerns or variance that had been identified on the electronic incident reporting system.
- **See information under this sub-heading in the surgery report.**

**Managing risks, issues and performance**

- **The service was committed to best practice performance and risk management systems and processes. The service reviewed how they functioned and ensured staff (in children's services) had the knowledge and skills to use those systems effectively.**
- At our previous inspection, children and young people were not identified within completed audits. This meant we could not be assured that risks were assessed, monitored and mitigated against. During the inspection we saw children and young people were included in the annual audit timetable. For example, children and young people audits into infection control, pain and patient information.
- We saw there was a risk assessment process in place and that identified risks were assessed using a

standardised template which scored the risk as low, medium or high risk. Local risks were held on a department risk register and were escalated to the health and safety committee for consideration for addition to the hospital wide risk register. Risks associated with children's services were identified on the hospital and departmental risk register.

- We spoke to the LPN about risks within their service and confirmed the risk register was discussed as part of the service performance review meeting. Staff were able to describe their understanding of what constituted as a risk.
- The LPN described the systems and processes which supported the monitoring of performance and issues. We saw there were online systems to monitor performance, for example, training compliance, and equipment maintenance. Staff were aware of their services performance and demonstrated how they had adapted performance audits to meet the needs of children and young people. This was an improvement from out previous inspection where audits and performance outcomes to measure the quality and effectiveness of children's services were not being collected.
- A lead paediatric nurse (LPN) now led children's services and additional registered nurses (child branch) had been appointed to the outpatient department. This meant there were appropriately trained staff always available to care for children and young people in the children's service. The MAC was attended by a group of consultants who had practising privileges and represented colleagues from each speciality including children and young people at the hospital. The MAC carried out checks before granting new consultants practising privileges, including checks on their scope of practice to ensure they were only undertaking procedures they were competent to perform. This included checking that operating on children was also undertaken in the consultants NHS practice.
- **See information under this sub-heading in the surgery report.**

**Managing information**

- **The service collected, analysed and managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Managers told us that there were electronic systems to manage some data and that was monitored by the quality improvement team. This included data for training compliance and audits. The LPN told us that performance measure data was reported to the executive team through reports shared at clinical governance meetings.
- **See information under this sub-heading in the surgery report section.**

**Engagement**

- **There were consistently high levels of constructive engagement with staff, children, young people and their parents and families and services were developed in participation with those who used them.**
- Children and young people's views on the experience of the care they had received were collected through a variety of methods which included children's surveys, 'You said, we did' boards and the friends and family test (FFT) and through patient related outcome (PROMS) interviews. Data for children and young people services in the period April to November 2018 showed there was an overall satisfaction score of 99% and response rates were above average. Results were shared at the children and young people governance meetings and at team and heads of department meetings.
- Staff in children's services were engaged in service developments. They told us they were supported by managers in developing ideas for making changes to services and that there was a staff innovation and employee engagement group set up to facilitate this.
- **See information under this sub-heading in the surgery report.**

**Learning, continuous improvement and innovation**

- **There was an embedded and systematic approach to improvement of children's services. Improvement methods and skills were available and were used across the service and staff (in children's services) were empowered to lead and deliver change.**
- There was a culture of improvement in children's services and staff were passionate about adapting services to make them more 'child centred'. The LPD was praised by staff from across the hospital for promoting

and ensuring that all staff caring for children and young people were confident and competent to care for children safely in whatever part of the hospital they were working in.

- Staff in outpatient services praised the appointment of registered nurses (child branch) to the service and told us how the care of children in the outpatient setting was now 'child centred'. This meant children received dedicated time and support from appropriately trained staff when they attended adult based services in the outpatient department.
- At our previous inspection we identified areas of concern. However, during this inspection we found concerns had been addressed and we found the following improvements:

1. Installation of security doors, key pads and buzzers to provide a secure environment for children and young people.
2. Implementation of child focused emergency simulation exercises with evidence of shared learning.
3. All staff caring for children and young people in the hospital had undertaken level three safeguarding children training.
4. Audits and performance outcomes (PROMS) for children and young people were being undertaken.
5. Children's services now employed registered nurses (child branch) to care and support children in the outpatient department.
6. Children undergoing elective surgery were cared for in dedicated, child friendly and age appropriate environments.
7. Staff were trained appropriately to care for children including in an emergency. For example, intermediate paediatric life support (IPLS), paediatric clinical competences and play therapy.
8. Implementation of risk assessments for children and young people.

- **See information under this sub-heading in the surgery report section.**

Good

# Outpatients

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

## Information about the service

Rivers Hospital is in Sawbridgeworth on the Essex /Hertfordshire border. Rivers Hospital is part of the Ramsay Health Care UK Ltd group and provides treatment for NHS patients, insured patients and those choosing to pay for their own treatment. The outpatients service sees both adults and children and young people.

The outpatient department is in two areas of the hospital; the main building and the Thomas Rivers building. It has 17 consulting rooms and three treatment rooms which are used for minor procedures. It offers the following services: allergy clinic, audiology, breast surgery, cancer services (including oncology), cardiology, care of the elderly, chest and respiratory, colorectal, cosmetic and plastic surgery, dermatology, diabetes and endocrinology, dietician and nutrition, ear nose and throat, fertility clinic, gastroenterology, general medicine, general surgery, gynaecology, obstetrics, haematology, lymphatic, nephrology and renal medicine, neurology, neurophysiology, ophthalmology and orthoptics, oral maxillo facial, orthopaedics, paediatrics, pain management, phlebotomy, podiatry, psychiatry, rheumatology, urology and continence, vascular and weight loss.

The physiotherapy department has seven treatment rooms and a large gymnasium.

During our inspection we observed how staff interacted with patients and spoke with nine patients and one relative of a patient attending the department. We spoke with a range of staff including two department managers, three nurses, four health care assistants, four administrative staff, a consultant and eight therapeutic staff. We also looked at six sets of patient records.

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

### Are outpatients services safe?

Good

Outpatient services were previously inspected as part of the outpatient and diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

**Mandatory training**

- **The service provided mandatory training in key skills to all staff and made sure most staff completed it.**
- The service followed the corporate mandatory training matrix that confirmed which training subject was required for each staff group. The matrix identified the type of training required; e-learning, face-to-face with an instructor, or a practical session, for example, and set out the timing that an update or review training was required.
- The 2018/9 corporate business plan had a target for all hospitals to improve mandatory training compliance to 90%. Staff in the outpatient's department met, or almost met, the 90% compliance target in most subjects. For example, the target of 90% was met in 51.8% of subjects as at October 2018. Compliance of between 80 to 89%

was achieved in 37% of subjects. Two mandatory training subjects, immediate life support (ILS) refresher training and dementia training, had compliance rates below 70%.

- Dementia training was included as an e-learning module as part of mandatory training for clinical staff; data provided by the trust showed compliance was 67% as at October 2018. The outpatient's manager told us the hospital had introduced a new electronic training system during 2018, and an error with transferring previous compliance data meant the current figure was not accurate. The manager confirmed 100% staff had completed the training and, to ensure compliance data was accurate, there was an action plan for staff to re-take the dementia e-learning modules.
- Nursing staff completed medicines management training; 100% of staff in OPD were compliant.
- Staff told us they received an email from the OPD manager to remind them to complete mandatory training and refresher training, and were also reminded in daily huddles and at staff meetings.
- **For details of mandatory training please see the Surgery report.**

**Safeguarding**

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- During our previous inspection in June/July 2016, the outpatient department manager and senior sisters were trained to level 3 safeguarding children's training which demonstrated there were sufficient numbers of staff trained to level 3 to manage the OPD safely. During this inspection, there remained sufficient numbers of staff trained to level 3 safeguarding and 94% of eligible staff across the hospital were compliant with the training; 89% of eligible staff were compliant with safeguarding children level 2 training. The data also showed that 87% of staff had completed their safeguarding adults mandatory training levels 1 and 2
- Safeguarding of children and adults training was undertaken every three years for levels one, two and three. Training was delivered in line with the Ramsay corporate safeguarding of children and young people; safeguarding adults; and intercollegiate documents. All safeguarding training was delivered in face-to-face sessions rather than in e-learning modules.
- There was an up to date corporate 'Safeguarding Adults Policy Incorporating Mental Capacity and Deprivation of Liberties and PREVENT for England and Wales' (dated May 2015) and 'Safeguarding of Children and Young People' policy (reviewed May 2017) with defined responsibilities at national, regional and hospital level. Prevent is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways to prevent people from being drawn into terrorism. The Prevent mandatory training was completed by 92% of staff across the hospital.
- Staff knew who the safeguarding leads were for both vulnerable adults and children, who were trained to level three. The leads cascaded information to staff, assisted with mental capacity act (MCA) assessments, and escalated or sought advice from the local trust's safeguarding team as required.
- The service had access to the Ramsay Health Care UK Ltd group regional safeguarding lead trained to level 4. This was in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.
- We saw that there was information displayed in each department on the actions to be taken and who to contact, in the event of adult or child safeguarding issues arising. Staff knew who to contact if the OPD manager was not available and told us the actions they would take if they suspected a safeguarding incident; this was in line with policy. For example, one staff member told us they had made a safeguarding referral when concerns were raised that an adult was at risk of harm. The staff member escalated the concern when a timely outcome was not received from the local authority; this meant we were assured staff followed policies and procedures to ensure children and adults were safeguarded.

**Cleanliness, infection control and hygiene**

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Clinical areas within outpatients were visibly clean and tidy.**

Good

# Outpatients

- At the time of our June/July 2016 inspection, some clinical hand wash basins in the outpatient departments did not comply with the Health Building Note (HBN) 00-09: Infection control in the built environment) because they had overflows and recesses that were capable of taking a plug. Overflows are difficult to clean and may become contaminated and a plug allows the basin to be used to soak and reprocess equipment that should not be reprocessed in such an uncontrolled way. During this inspection, some clinical hand wash basins did not comply with HBN 00-09 regulations. A risk assessment was completed for non-compliant hand-wash basins with actions to reduce the risk of overflow and infection.
- Rooms used for clinical procedures were adequately equipped to maintain safety and complied with infection control standards. Appropriate air filtering systems and air changes were in place for the minor operations procedure room.
- There were reliable systems in place to protect and prevent people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired methicillin-resistant staphylococcus aureus (MRSA), Methicillin-susceptible Staphylococcus Aureus (MSSA), C.diff, E.Coli or surgical site infections in the reporting period July 2017 to June 2018.
- There were sufficient handwashing sinks and hand sanitising gel within the departments we visited. Staff followed their corporate 'Hand Hygiene' policy which included types of hand hygiene, soap and water, and wearing of jewellery. Staff in all the departments we visited were observed adhering to 'arms bare below the elbow' guidelines.
- The hospital had an infection prevention and control annual programme action plan for 2017/2018. The hospital had systems in place to manage and monitor the prevention and control of infection, and data was reviewed by the infection prevention and control committee.
- The physiotherapy department had an action plan in place following an IPC audit to ensure the blue chairs in the department were cleaned to remove any stains.
- As at October 2018, 76.4% of eligible staff had completed IPC training and 92.6% of staff had completed aseptic non-touch technique (ANTT) and sepsis training. (Aseptic technique is a process aimed at protecting patients from infection during invasive procedures, such as when taking blood cultures).
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when performing procedures. A review of the correct use of PPE was completed with staff following an incident in 2018, when a nurse undertook wound care without the use of gloves for a patient with a blood borne virus. The IPC Committee September 2018 minutes, reported that staff in the outpatient's department and phlebotomy (blood-taking clinic) must wear PPE in line the policy. One phlebotomist told us, however, they did not wear gloves when taking blood as they found this more difficult.
- We observed one consultant leaving a clinical area wearing gloves and disposing of them in a domestic, rather than a clinical waste bin. We raised this with nursing staff who took immediate action to dispose of the gloves safely and advised they would remind the consultant of the PPE policy.
- The examination couches seen within the consulting and treatment rooms were visibly clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.
- We saw 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), health, and safety at work regulations.
- 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.
- The PLACE assessment for cleanliness for the period March to June 2018 was 100%, which was better than the England national average of 98.5%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.

**Environment and equipment**

Good

# Outpatients

- **The service had suitable premises and equipment and looked after them well.**
- The outpatient service had 18 individual consulting rooms, and three minor procedure rooms, used for minor operations such as lumps and bumps and treatment. There was a dedicated physiotherapy suite with seven treatment rooms and a gymnasium; all departments were tidy and well equipped.
- All rooms were locked when not in use with either keypad or key access. The consulting rooms were tidy and equipped with a desk and chairs for discussions with patients, and a couch area for procedures.
- There were 'sharps' bins available in all the consultation rooms and we noted the bins were correctly assembled, labelled, and dated. None of these bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.
- The service had rooms allocated to specialties which were prepared with appropriate equipment for investigations or treatment. This enabled equipment to be easily accessible to reduce waiting time.
- Consulting rooms were carpeted which was not in line with HBN 00-09 which advised that carpets should not be used in clinical areas. The environment was listed on the departmental risk register and mitigating action was taken to ensure cleaning procedures for carpets were followed. There were no immediate plans to replace the carpets at the time of our inspection.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of March to June 2018, showed the hospital scored 96% for condition, appearance, and maintenance, which was better than the England average of 94.3%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.
- Staff in the physiotherapy department had competency documents to show they were trained in the use of specialist equipment, this meant the hospital ensured staff were safe and competent to use equipment with patients.
- Resuscitation equipment and medicines for adults and children were available in the department or in adjacent departments. All trolleys were locked and records indicated that the trolleys were checked daily on days when clinics operated. All drawers had correct consumables and medicines in accordance with the checklist. We saw consumables were in date and trolleys were clean and mostly dust free. The automatic electrical defibrillator worked and suction equipment was in order where it was present. We observed the resuscitation trolley in the Thomas River wing was dusty and a suction machine had been on order since October 2018. In mitigation, three other portable suction machines were available from adjacent treatment rooms.
- There was a service level agreement with the local acute NHS trust for the decontamination and maintenance of equipment. All electrical equipment in the departments had been serviced. Staff reported that equipment was usually returned to the department within 24 hours, and stated they had sufficient equipment to meet the demands of the service.
- Clinical waste was segregated appropriately and removed from the department at regular intervals.
- Legionella testing was completed every three months and pseudomonas testing monthly. Minutes of the September infection prevention and control committee confirmed that neither legionella or pseudomonas was detected in the August water test.

**Assessing and responding to patient risk**

- **Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Updated risk assessments were completed for each patient and staff kept clear records and asked for support when necessary.**
- Systems and procedures were in place to assess, monitor and manage risks to patients. The service always had access to a resident medical officer (RMO), provided by an external provider. The RMO was trained in advanced life support and advanced paediatric advanced life support (APLS). The RMO provided support to the outpatient staff if a patient became unwell. Patients identified as being unwell upon arrival to the department were reviewed and patients were referred to the inpatient area for admission when appropriate.

- The hospital used the National Early Warning Score (NEWS 2) for all patients in line with the National Institute for Health and Care Excellence (NICE) guidelines, relating to recognising and responding to the deteriorating patient. This was used to record routine physiological observations such as blood pressure, temperature and heart rate, with clear procedures for escalation if a patient's condition deteriorated. Nursing staff described the process and explained who they would contact in an emergency.
- A phlebotomist told us that, when a patient fainted, they did not always escalate to a nurse-in-charge and managed the patient until they felt well enough to leave the clinic. Following our inspection, the hospital confirmed that if the 'light headedness' had not subsided within 30 seconds then the crash call button would be used, and nominated staff would respond immediately to the incident.
- If a patient became generally unwell during a procedure, or whilst they were waiting for treatment, they would be moved to a clinic room and the RMO would take observations and examine the patient. Refreshments were provided for patients whose blood sugar levels were low and hypoglycaemic medications (to raise blood sugar levels) were available on all resuscitation trolleys.
- During our inspection we saw staff follow emergency procedures when a call bell was used to alert other staff when a patient had deteriorated. We observed staff responded immediately to the emergency call and we were therefore assured that processes and policies were followed to ensure patient care was safe.
- The service followed the corporate "Recognition and Management of the Deteriorating Patient" policy which set out criteria for transferring a patient to a local NHS hospital for higher acuity care, such as level 2 or 3 critical care. Staff described the process and their actions and confirmed they had received training in the recognition of a deteriorating patient. Staff told us that they had not been required to transfer a patient to the local NHS hospital and would record this as an incident if the situation arose.
- Sepsis training was part of the mandatory training and all outpatient staff were compliant. The deteriorating patient policy included guidance and treatment pathways for sepsis, such as sepsis six guidance.
- The outpatient's service had processes in place to assess the risk to patients using the service and developed risk management plans in line with national guidance. Risk assessments were carried out at pre-assessment, and reviewed throughout the patient pathway.
- All patients were seen within the national recommended referral to treatment times which minimised the risk of patient harm.
- Patients had their bloods taken as required in the on-site pathology lab for analysis. Some blood tests, such as blood cultures, were sent off-site to a laboratory. Staff could access the test results using an online portal.
- All outpatients were under the care of an appropriate consultant who had practising privileges at the hospital. Practising privileges ensured that all health and social care professionals involved with patient or client care are qualified, competent and authorised to practice.

**Nurse staffing**

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**

- During this inspection, there were no vacancies within outpatients or physiotherapy, and there had been no staff turnover from August 2017 to July 2018. Most vacant shifts were filled by bank staff who were known to the service. When necessary, such as if a registered sick children's nurse (RSCN) was required for a vacant shift, agency staff were appointed.
- The service used a recognised baseline staffing tool to monitor staff levels. Staffing levels across the service were reviewed in advance on a weekly basis and daily within a meeting held each morning with service leads. We observed that patient appointments and staffing levels/skill mix were reviewed during our inspection. Staff were allocated to clinics according to the activity to ensure patient care was safe.
- Staff were appropriately skilled and had completed training relevant for their roles. There were 16 qualified nurses and 12 health care assistants (HCAs), and additional clinical nurse specialists such as an irritable bowel syndrome, breast care, and a tissue viability nurse who ran nurse-led clinics. Two full-time RSCNs had been recruited during 2018 to support the service.

- A registered nurse was allocated to both 'corridors' in the main OPD area to ensure safe staffing was maintained at all times. All qualified nurses were trained to support each clinic to provide flex with arranging cover at short notice.
- Staff members including health care assistants (HCAs) and reception staff supported clinical staff.
- There was a team of 16 full and part-time therapy staff in the physiotherapy department, including physiotherapists and technical assistants, who provided inpatient and outpatient care. The service also used physiotherapists to provide cover on the ward and in clinics at the weekend.

**Medical staffing**

- **The service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.**
- There were no medical staff employed directly by the service, with all consultants working under practising privileges. Practising privileges are granted to doctors who treat patients on behalf of an organisation, without being directly employed by that organisation. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Consultants new to the hospital received a formal induction, and could work under practising privileges only for their scope of practice covered within their NHS work. Details of consultants working at the hospital can be found in the surgery report.
- Consultants with practising privileges were required to be contactable always when they had a medical patient at the hospital or were expected to confirm at least one colleague as cover in their absence. Nursing staff told us that they could call and speak with the consultants at any time for advice if a patient had contacted them with a request to bring forward an appointment, for example.
- The hospital director and medical advisory committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- The hospital had resident medical officers (RMOs) who provided a 24-hour a day, seven days a week service, on a rotational basis. The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support.
- Staff in the outpatient department told us they experienced issues with consultants not arriving for clinic at times. They told us in the event a clinic had to be cancelled at the last minute, the outpatient staff would ring every patient and where possible stop them from attending. They would rebook them onto the next available appointment.
- There was sufficient consultant staff to cover outpatient clinics. All staff we spoke with told us they had very good relationships with the consultants.

**Records**

- **Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to staff providing care. There was a corporate medical records management policy, that had a review date of December 2018.**
- We saw that the outpatient and physiotherapy departments stored records safely and securely in line with the Data Protection Act, 1998.
- All patient NHS and private patient records were kept in a standardised corporate file. These ensured patient records were always available for clinics. Patient records were recalled from a medical records store in time for the patient's outpatient appointment, or a patient record was set up for new patients.
- Medical staff, who kept their own private patient records, took photocopies of patient notes if they were seeing them elsewhere, and took responsibility for the safe management of patient records off site. Nominated staff could access NHS patient records on an electronic patient record system.
- The service used a paper based record system for recording patients care and treatment. We reviewed six patient records and found that all were clear and legible. The December 2018 patient record audit, confirmed there was evidence that the intended benefits and risks of a procedure were discussed with the patient in all ten records reviewed.

- We observed that timely communication was made with GPs to detail treatment plans, actions taken, medication and details of next appointments in all (100%) of files we reviewed.
- Following a peer review audit of physiotherapy patient records in October 2018, we observed there was an action plan in place for staff to ensure treatment plans, including the 'goals' section, were fully completed, and contemporaneously.
- Data received from the hospital indicated that 73% of the required hospital-wide staff had completed their mandatory training in information security, as at October 2018. This was below the hospital target of 90%. This meant the hospital could not always be confident staff were aware of their roles and responsibilities to keep patient information safe.
- Computers were locked when not in use. This prevented unauthorised access and protected patient's confidential information.

**Medicines**

- **The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.**
- The hospital had a medicines management policy for the safe management of medicines dated April 2018. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs.
- Consultants were responsible for the prescribing and administering of all medicines for patients attending the service. Patients who were provided with a prescription could have it dispensed by the on-site pharmacy that was available Monday to Saturday.
- Medicines were supplied by the on-site hospital pharmacy and medication was stored securely in locked cabinets in rooms that required keypad access. Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, so would be fit for use.
- All medicines stored in cabinets and refrigerators were found to be properly stored in intact packaging and were in date.
- All medicines cabinets and refrigerators had thermometers and we observed daily temperatures were completed. There were no temperatures out of range during November 2018 which meant the storage of medicines was safe. The checklist, where staff signed to confirm they had completed required safety checks, did not include a box to evidence the fridge was reset when required. A sign was placed on the fridge to remind staff to reset the fridge however, there was no assurance that this had always been carried out.
- Patient group directives (a written instruction for the supply of a particular medication) were used by the occupational health nurse to enable a repeat supply of the flu vaccine to be provided for staff members. All other prescriptions for drugs were written at the time of the patient's consultation.
- Blank prescription pads were stored securely and there was a process in place to identify which doctors had used them.

**Incidents**

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**
- The hospital followed their corporate 'Incident Reporting' policy (dated September 2016). Heads of departments and clinical leads had completed route cause analysis (RCA) training. RCA was on-going for staff to improve incident reporting, the quality of data provided, and to increase understanding of how incidents happen, and how staff can prevent and/or correct errors.
- There were no never events or serious incidents reported in the OPD department during the previous 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff had received training and told us they were encouraged to report incidents however, not all staff had been required to report an incident. Most staff provided us with examples of feedback following investigations of incidents. For example, information

was put on display in the main reception waiting areas asking parents not to leave children unattended when they attended an appointment. This followed an incident when a child was left on their own.

- The incident feedback shared learning group reviewed all incidents across the hospital. The hospital's strategy for 2018/19 identified the continuation of shared learning through audits, incidents and adverse events and complaints. The hospital introduced lessons learned sessions for 2017/18, and some OPD staff HAD attended a session. The hospital confirmed these would continue to run for 2018/19 to ensure that shared learning from significant events and preventing similar incidents happening in the future.
- All incidents and adverse events were also discussed at the monthly and senior management meetings and at staff monthly meetings. We saw minutes that confirmed this.
- Staff described the principle and application 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 person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the corporate "Being Open" policy. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened**.**

**Safety thermometer**

- **The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.**
- **See information under this sub-heading in the surgery report.**

## Are outpatients services effective?

We currently do not rate effective for outpatient services.

**Evidence-based care and treatment**

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Specialities within outpatient services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. New, or recently reviewed NICE guidance, was a standard agenda item and discussed in medical advisory committee meetings. The September 2018 minutes confirmed that NICE guidance updated between April and June 2018 was shared at the meeting.
- Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff in outpatients and physiotherapy had a good awareness of and had read local policies. They could give us examples of how to find policies and when they had used them.
- We saw examples of policies referring to evidence based guidance from professional bodies. For example, the chaperone policy referred to recent professional guidance from the General Medical Council, and the consent to treatment for competent adults and children/young people referred to the Mental Capacity Act 2005.
- The hospital had an audit programme, and collated evidence to monitor and improve care and treatment. We were provided with the local audit programme for the hospital, which was set corporately by the Ramsay Health Care UK Ltd group. The hospital was able to benchmark the results from the audits with other hospitals within the Ramsay Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the World Health Organisation (WHO) safer surgery checklist, and medicines management. We saw evidence that actions were taken to improve compliance where indicated.
- **Please see the surgery report for further details.**

**Nutrition and hydration**

- **Although outpatients visited the department for short periods of time, staff ensured patients had enough food and drink to meet their needs during their visit.**
- A range of refreshments were available for patients from vending machines situated in the main reception area.

- Reception staff told us they offered patients who appeared anxious or distressed a drink and provided assistance to patients who required additional support to purchase refreshments.
- We observed that the patient appointment letter detailed whether patients were able to eat and drink prior to their appointment or scheduled procedures.
- The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit March to June 2017, which showed the hospital scored 92.7% for organisational food which was better than the England national average of 90%.
- A service level agreement was in place with the nutrition and dietetic team at the local NHS trust. This meant that they could provide staff with advice and assess patients who required additional support.

**Pain relief**

- **Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Patients we spoke with had not required pain relief during their attendance at the outpatient departments.
- Pain relief was not routinely administered within the service as patients attended for short periods and usually took analgesia prior to attendance. Nursing staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care.
- Pain was risk assessed and recorded using the National Early Warning Score (NEWS 2) scale that included a pain scoring tool of 1-3. If a patient required urgent pain relief and the consultant was unavailable, the registered medical officer would assess the patient and prescribe the relevant pain relief.
- Staff in the physiotherapy department completed treatment plans that aimed to reduce or help support patients manage their pain. We observed written feedback which read "You are a true professional and always make me feel at ease. …my life is so much better without the pain".
- Pain advice booklets were provided to patients undergoing minor procedures and GPs were advised of a patient's treatment and prescription plan to support continuity of care on discharge from the outpatients department (OPD) service

**Patient outcomes**

- **The service monitored the effectiveness of care and treatment in some areas and used the findings to improve them. They compared local results with those of other services to learn from them.**
- The OPD participated in national 'patient reported outcome measures' (PROMs) and in the national joint registry (NJR). Results were monitored and discussed at the hospital's clinical governance and medical advisory committees on a monthly basis, as well as at a regional and corporate level. Outcomes were benchmarked against other comparable services and, where poor outcomes were identified, action plans were in place to improve performance. For example, an action plan to improve PROMs concerned providing an early follow-up appointment for patients who struggled with obtaining a full range of movements.
- The physiotherapy department collected patient outcomes following the delivery of a functional restoration programme (FRP). The FRP was an exercise based class and healthy living group which aimed to train patients with persistent pain to become experts at managing their pain, and improving their function and quality of life. The outcomes evidenced a reduction in the number of GP visits NHS patients attended. The service won a corporate award in recognition of the practice. Whilst funding for NHS patients was not continued at the time of our inspection, private patients continued to benefit from the programme.
- An inflammatory bowel disease specialist nurse had been employed to support patients on long-term treatment programmes with the aim of improving patient outcomes.
- An ear, nose and throat consultant told us they did not participate in audits at the hospital.
- The physiotherapy team had an action plan in place to improve the timeliness of patient discharges from the services following an audit. This included ensuring all patients who required social care support were identified and referrals made when required. The plan also aimed to improve patient care by ensuring all patients were provided with the correct exercise regime and booklets to support them at home

**Competent staff**

- **The service made sure staff were competent for their roles. Managers appraised staff's work**

**performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Staff we spoke with confirmed they had completed all mandatory training and competency assessments and told us they were given time to complete electronic learning.**

- Throughout our inspection, we found staff received training to support the delivery of care and individual's developmental needs.
- All new employees underwent an induction and competencies were assessed and reviewed as required.
- The heads of department confirmed they had assessed staff to ensure they were competent in their role. We saw a competency folder in place which demonstrated staff had been appropriately assessed.
- The head of department monitored staff competence and skills. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and one to one meetings with their manager.
- Staff within the OPD and physiotherapy department had attended both local, external and corporate courses. These included; dealing with difficult people, effective leadership skills and automated external defibrillator (AED) training. AED training ensured staff had the necessary skills needed to respond to an emergency until medical services arrived.
- Evidence showed that 100% of OPD staff had received an appraisal, which were recorded on the corporate electronic recording system. Staff told us development opportunities were identified during their appraisals and that they felt supported to request additional training at other times as required. For example, one member of staff began employment at the hospital as a receptionist and had been supported to complete a physiotherapy technician apprentice. A physiotherapist was trained in providing cognitive behavioural therapy for pain management.
- HCAs told us they were supported with development opportunities, one had engaged on registered nurse training and two further HCAs had expressed interest in following this training pathway.
- Some staff had completed the corporate leadership programme, and a lead registered sick children's nurse and a registered nurse had registered to begin the course.
- The hospital ensured qualified nursing staff continued to maintain their registration. Information supplied by the hospital showed 100% completion rate of validation of registration for nurses and for doctors working under practicing privileges.
- Consultants applying for practising privileges had to demonstrate their competency prior to undertaking any new procedures in the OPD. This was done by seeking evidence from their NHS practice.
- The hospital training plan was reviewed quarterly in heads of departments quarterly meetings.

**Multidisciplinary working**

- **There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.**
- There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. All staff, clinical and non-clinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.
- Staff told us they were proud of their multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another. Medical and nursing staff reported good working relationships.
- Speciality MDT meetings were not often held however, a urology MDT was held with radiologists.
- Physiotherapists worked collaboratively with OPD and ward staff to ensure patients received a timely and streamlined service. Staff also worked alongside wound care nurses to ensure the best delivery of care and treatment options was provided.
- Physiotherapy staff accompanied patients to the radiology department at weekends when no porters were available. The practice was evidence of good collaborative working and communication with staff between departments.

- There were a number of service level agreements in place with nearby organisations, which involved teamwork to ensure continuity of care for patients. For example, an agreement with a neighbouring trust enabled patients to receive dietician support as required.
- We observed in patient records that GPs were kept informed of treatments provided; follow up appointments, and medications to take on discharge.

**Seven-day services**

- **There was a six-day service provided by the outpatient's service.**
- The outpatient department ran clinics from 8am to 9pm, Monday to Friday and 8am to 3pm on Saturdays as required. Staff cover was provided between these times.
- Since the previous inspection in June/July 2016, the physiotherapy had extended its hours and was open from 8am to 7pm Monday to Thursday and 8am to 3.30pm on Fridays. The department was also open each weekend when appointments had been booked.
- Resident Medical Officers (RMOs) provided a 24 hour a day, seven days a week service on a rotational basis. All RMOs working at the hospital were selected specifically to enable them to manage varied patient caseload.
- The pharmacy service was open 9am to 8.30pm on Mondays and Tuesdays, 9.00am to 6pm Wednesday to Friday, and from 9am to 2.00pm on Saturdays. An on-call service was available on Sundays.
- The phlebotomy clinic was open from 8.30am Monday to Friday and provided two evening clinics until 8pm on a Tuesday and 7pm on Fridays. The clinic was also open until 12.30pm on Saturdays.
- The physiotherapy service provided a seven-day, telephone service to access support and advice.

**Health promotion**

- **The service supported people to live healthier lives and care was planned holistically using health assessments where appropriate.**
- The service demonstrated it had introduced improvements to meet the Commissioning for Quality and Innovation (CQUIN) national goals; Improvement of health and wellbeing of staff. For example, fast-track access to physiotherapy for staff with musculoskeletal issues was available; staff also had an opportunity to join physical activity schemes and access to 24-hour helpline for advice around issues such as stress and anxiety, for example.
- All hospital staff were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients.
- Physiotherapists provided patients with written exercise regimes to support their rehabilitation within the community.

**Consent, mental capacity act and deprivation of liberty safeguards**

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**
- The service followed their corporate 'Mental Capacity Policy' (due for review June 2020), which included responsibilities and duties, training, key principles assessing capacity, best interest and refusal to be assessed.
- Staff completed Mental Capacity Act and Deprivation of Liberty Safeguards training within the safeguarding adult's mandatory training.
- Staff in outpatients and physiotherapy told us they rarely encountered patients with dementia or who lacked capacity. However, they were able to describe the process they would follow if they suspected a patient lacked capacity, and knew who to contact for further support or advice on this. One member of staff told us of the process they followed when a patient was disorientated and displayed challenging behaviour in the OPD waiting area.
- Contact details for the hospital safeguarding lead and the local safeguarding team were displayed in the nurse's office, so staff would know who to contact if they had any concerns.
- Initial consent for surgery was completed by the consultant providing care in the outpatient's department. All patients undergoing surgery were consented by the consultant providing care during outpatient consultation. The six patient records we reviewed had consent clearly recorded and documented in writing, and the patient had also signed

the stage 1 consent form. The December 2018 patient record audit, found that the consent process and recording of patient details was followed in each of the ten records reviewed.

- Patients told us they had been given clear information about the benefits and risks of their surgery in a way they could understand before signing the consent form.
- Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.

## Are outpatients services caring?

Good

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good.We rated it as **good.**

- **Compassionate care**
- **Staff cared for patients with compassion. All patients we spoke with were highly complementary of the care they had received in outpatient services and many had used the services for a length of time. Patients and their relatives told us staff were extremely friendly and helpful.**
- Patients were treated with respect and compassion throughout their care within outpatient services. Staff responded sympathetically to queries in a timely and appropriate way. We observed caring interactions with patients whilst they were booking in at the main reception or being assisted in the departments. One patient told us "It's perfect. All the staff go out of their way to help you, including the porters".
- Throughout our inspection, we saw patients were treated with compassion, kindness, dignity, and respect. We received comments such as, "I think they're all excellent. I can't think of anything to improve on", and "I can't praise all the staff highly enough on the manner in which I've been treated".
- Staff respected patients' social, cultural, and religious needs. We observed positive interactions between staff, patients, and relatives. Staff introduced themselves and took time to interact in a considerate and sensitive manner. We observed all reception staff went out of their way to greet patients kindly, and one staff member told us, "This job is something you do from your heart".
- Consulting rooms were fitted with a code controlled lock. Staff were observed to knock on doors before entering when patients were in treatment areas and consulting rooms.
- Women's health patients in the physiotherapy department were treated in a locked room, to ensure their privacy.
- The Patient Led Assessment of the Care Environment (PLACE) assessment for the period of March to June 2018 showed the hospital scored 83.6% for privacy, dignity, and well-being, which was lower than the England average of 84.2%. The score represented a deterioration from 2017 when the hospital scored 88.3%. The place assessment for privacy, dignity and well-being, focuses on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also includes the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients were appropriately dressed to protect their dignity.
- The hospital obtained patient feedback in a number of ways. The Friends and Family Test (FFT), enabled patients to submit feedback using a simple question which asked how likely, on a scale ranging from extremely unlikely to extremely likely, they were to recommend the service to their friends and family if they needed similar care or treatment. From February to July 2018, monthly scores were 100%, with the exception of May 2018, which was 98%. This remained above the England average score of 94%. Response rates were low compared to the England average, and ranged from 5% to 9%. For example, in May 2018 the England average response rate was 12.5%.
- There were posters in reception and around clinical areas with details about how patients could provide feedback or complain. The service used a 'We value your opinion' survey and a patient satisfaction survey to review the service. Patients were also able to provide feedback in waiting areas. For example, patients who visited the physiotherapy department were routinely asked to provide feedback, and we observed comments recorded in a book in the reception area.

- Senior managers told us that they would always offer to meet with patients and family if they were unhappy with the care they received.

**Emotional support**

- **Staff provided emotional support to patients to minimise their distress. Patients and relatives told us they felt their emotional wellbeing was cared for.**
- Staff had a good awareness of patients with complex needs and those patients who may require additional support, should they display difficult behaviours during their visit to outpatients.
- The pathway for each procedure prompted the nurse assessor to ask a question in relation to patient anxiety and expectations. Information was available to patients undergoing cosmetic procedures to enable them to consider any potential emotional impact and support that may be accessible.
- Patients we spoke with told us they knew who to contact if they had any worries about their care and said staff had supported them emotionally as well as physically, where there had been bad news following diagnostic results.
- Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.
- Qualified registered sick children's nurses (RSCNs) accompanied children to appointments and used distraction techniques and reassurance to support their emotional wellbeing.

**Understanding and involvement of patients and those close to them**

- **Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the staff looking after them. Relatives we spoke with said they had been given time with the nurses and doctors to ask questions.**
- Throughout our inspection, we observed staff introduced themselves to patients and explained their treatment and care options.
- We saw appointment letters, which contained clear information about appointments and what to expect. Booking administrators sent information about how to get to the hospital and specialist information depending on which clinic they were attending. All patients told us they were provided with a good, clear explanation and most were provided with written information about their condition. One patient told "the staff always explain everything twice".
- A patient's relative told us they had had been kept 'well-informed' of the care plan and were given time to any questions they had. A telephone number was provided and the patient was advised to request any further information once they left the hospital if they had a query.
- All outpatient services offered patients a chaperone and departments clearly displayed signs in waiting areas and consulting rooms. Patients were given the opportunity to be accompanied by a friend or relative and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants were available to act as chaperones when required. The November and December 2018 OPD patient record audits, showed that 100% of patients were offered a chaperone.

## Are outpatients services responsive?

Good

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good.We rated it as **good.**

**Service delivery to meet the needs of local people**

- **The outpatient department (OPD) planned and developed services to meet the needs of the local population for both private and NHS patients.**
- The service reflected the needs of the population and provided flexibility, choice, and continuity of care. Patients attending the hospital OPD were a mix of privately funded and NHS funded patients. These patients had chosen the hospital as a location for their appointment through the NHS e-referral service. When asked about choice of hospital one patient told us, "I had a choice of three hospitals and came here. That answers the question".

Good

# Outpatients

- The service had good working relationships with the local clinical commissioning group to manage services for NHS patients. This meant that local commissioners were involved in the planning of local services. Local agreements were in place with the local NHS trust for the provision of services, such as nutrition and dietetic services and pharmacy.
- The OPD and physiotherapy departments offered early and late appointments, as well as appointments on Saturdays. Patients could also telephone for advice outside of their appointment times.
- A clinical nurse specialist had been employed to deliver a nurse-led, inflammatory bowel disease clinic to meet the needs of local people.
- The OPD clinics and physiotherapy department were clearly signposted, and staff directed patients to the relevant areas.
- Facilities and premises were not always appropriate for the services that were planned and delivered. The main outpatient reception was in the main entrance of the hospital and was easily accessible to patients. The waiting area was spacious and provided comfortable and adequate seating for all patients who attended the OPD. A section of the waiting area contained toys for children.
- The waiting area in the Thomas Rivers building however, was small and the reception area was cramped. We observed the area was busy during our inspection and conversations at the reception desk could be overheard from the seats in the waiting area. A sign at the reception desk indicated where patients should wait to give more privacy to patients at the desk. Staff told us that if patients asked to discuss matters in private they would take them to a vacant consulting room if it was possible to do this, but that patients' privacy could not always be maintained in the departments. The hospital was aware of the size of the waiting rooms and were reviewing plans for refurbishment.
- The physiotherapy department had a separate waiting area that was appropriate for the services that were planned. The service provided a range of classes in the gym to suit patient's needs, which included group and individual classes. The classes were held in the afternoons and evenings and included provision for people with a sports injury.
- Where possible, the service provided one stop clinics where all investigations, diagnosis, and treatment planning was carried out in one day, for example there was a one stop breast clinic. A patient told us "I saw the consultant, had an x-ray, then saw the consultant again within 30 minutes".
- The hospital had confirmed there was limited car parking facilities which impacted on the needs of patients during times of increased activity. Patients spoken with confirmed that parking at the hospital could, at times, be difficult. We observed the beginning of a physiotherapy exercise class and one patient arrived late due to parking difficulties. Parking was free and the hospital continued to review all options and had created some additional parking spaces. Due to the location of the hospital, car parking was limited.
- General information leaflets relating to most services provided, including complaints, were also available in the waiting areas.
- Written information on medical conditions, procedures and finance was available and accessible throughout the department.
- **See information under this sub-heading in the surgery report section.**

**Meeting people's individual needs**

- **The service took account of patients' individual needs.**
- **T**he service identified the communication needs of people with a disability or sensory loss at the referral or initial appointment stage.
- Patients were provided with a leaflet, "How we communicate with you" which explained how the service would store and use their personal information in patient records. Patients were given an option to confirm how they wished the service to communicate with them for example, by telephone, email, text message.
- The service provided appropriate translation services, hearing assistance, sign language interpreters or other assistance to ensure the individual needs of the patient were considered.
- Patients told us that they were given detailed explanations about their admission and treatment as well as written information. Staff confirmed that written information could be obtained in other languages if required.
- Patients were sent information about a specific condition or procedure required prior to their visit. One

patient told us they had received a leaflet about a cataract that they found helpful. However, the hospital did not provide this information in different formats, for example in other languages for people whose first language was not English. Information regarding common children's procedures was available for parents, however, we did not see any information leaflets specifically designed for children.

- A range of refreshments were available for patients in the main reception areas.
- High-back chairs were available in most waiting areas to accommodate older patients or those with mobility issues. We also observed that bariatric chairs (for heavier patients) were also available in the main outpatients waiting area, and bariatric wheelchairs and trolleys were accessible throughout the department.
- Managers had met with Jehovah's Witness liaison officers who had delivered staff training to improve their understanding of patient personal beliefs and preferences regarding blood transfusions.
- There were procedures in place to make sure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs, and aimed to ensure that patients understood the costs involved. Leaflets were available that explained the payment options, and procedures and gave advice of who to contact if there were any queries. The hospital website also clearly described the different payment options available. The hospital had received a number of complaints regarding the cost of treatment, and action had been taken to inform patients that additional costs could be incurred when x-rays, for example, were required. Information was also displayed on notice boards to inform patients that additional costs may be incurred in some circumstances.
- The OPDs were accessible to patients with a physical disability, as patient lifts were available. Some waiting areas made it difficult to manoeuvre a wheelchair however, consultant rooms were accessible.
- Staff told us on some occasions they arranged, and the service funded a taxi for NHS patients when the transport was significantly delayed. This was to meet the individual need of the patient.
- The admissions process had been reviewed to ensure the services delivered were accessible and responsive to people with complex needs. This included identifying patients with mental health needs or those living with dementia. All staff were supported to complete dementia awareness training and the hospital had built relations with the dementia link nurse at a local NHS trust.
- Patient Led Assessment of the Care Environment (PLACE) for the period March to June 2018 showed the hospital scored 79.9 % for dementia, which was lower than the England average of 82.4%. The place assessment for dementia was included for the first time in 2015, and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- The PLACE assessment for the period of March to June 2018 showed the hospital scored 79.9% for disability, which was lower than the England average of 84.2%. The place assessment for disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which could prove helpful to people living with disability.

**Access and flow**

- **People could mostly access the service when they needed it. Waiting times from referral to treatment were in line with good practice.**
- There were 11,392 NHS funded patients who attended the outpatient department for their first appointment from August 2017 to July 2018. There were 50,445 NHS funded patients who attended the outpatient department for follow up in the same period.
- There were 8,561 patients who were funded either from insurance or self-pay schemes who attended the outpatient department for their first appointment from August 2017 to July 2018. There were 29,466 of this group of patients who attended the outpatient department for follow up in the same period.
- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All hospitals that treat NHS patients are required to submit performance data to NHS England, which then publicly report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments was 18 weeks from the day a patient's appointment is booked through the NHS e-Referral service,or when the hospital or service receives the referral letter.

Good

# Outpatients

- All NHS waiting times were monitored and reported monthly to ensure the service was compliant. From August 2017 to July 2018, the hospital's referral to treatment time (RTT) for incomplete pathways (patients waiting to start treatment within 18 weeks), showed performance was significantly better than the England average. Overall, an average of 99% of NHS patients, received a first consultant appointment within 18 weeks against the England average of 92%.
- All private patients received an appointment within 72 hours and urgent appointments were available within 24 hours.
- During this inspection, we reviewed six patient records which confirmed all (100%) of non-admitted patients were seen within 18 weeks of referral.
- We observed that patient access and flow was discussed at a daily '10 at 10' meeting. This included all senior staff members. The number of new and follow-up clinic appointments, and the number of patients undergoing minor treatment were discussed. The meeting enabled key safety information to be shared with each department, identified any risks to the service, for example staff sickness, and enabled information to be cascaded to staff across the department each morning.
- Patients could book appointments on the NHS 'Choose and Book' portal that provided patients with a choice of appointment time. Private patients could book appointments through the centralised team or the website, and bookings administrative staff screened referrals and referred to the appropriate specialism.
- Access to outpatient appointments was fast and patients told us they were more than satisfied with the amount of time it had taken to obtain an appointment. Patients also told us they were able to book appointments at times that suited them. Access to physiotherapy services was fast and group classes meant appropriate patients could begin sessions in a timely way.
- Appointments were available at weekend clinics according to clinical need.
- On arrival, patients reported to the receptionists who logged them in via an electronic booking system and directed them towards the appropriate clinics and waiting areas.
- Staff managed patients who did not attend clinics; the hospital had very low 'did not attend' (DNA) rates. For example, in November 2018 the DNA rate for NHS patients was 2.7%. All private patients who missed their appointment were followed up and offered a further appointment within 28 days. NHS patients were referred back to their GP after one DNA and they would need to re-refer the patient.
- Care and treatment was only cancelled or delayed when necessary. Clinic cancellations and DNAs were monitored and reported to the local CCG. The patient system was accessible to consultants at the hospital and they were able to book any vacant clinic slots to run clinics.
- Staff monitored clinic delays. During 2018, 2.9% of patients experienced a delay of an hour; 4.2% experienced a delay of 45 minutes; and 6.4% experienced a delay of 15-30 minutes. Receptionists reported that patients were individually told if there were delays and that it was noted that an apology was given on the OPD clinic list. One patient told us they had visited the hospital "…for years" and that there had been times when they had experienced long delays however, they always received an apology.
- Action had been taken to address clinic delays to improve patient satisfaction. For example, consultant slots were changed if they were unable to regularly attend on time; additional consultant time was requested for complex NHS patients; and a registered sick children's nurse was allocated to all children and young people's appointments.

**Learning from complaints and concerns**

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- Complaints had been identified as an area of improvement on the quality improvement action plan for 2018/19. This included improving systems in place to provide feedback to all staff related to patient incidents, trends and any learning.
- The hospital had a clear process in place for dealing with complaints, a 'management of patient complaints' dated November 2016. Staff we spoke to were aware of the complaints procedure. We saw complaints leaflets were available throughout the hospital; complaints could be made in person, by telephone, and in writing by letter or email.
- Staff said that if a patient raised a concern or wanted to make a complaint they would try to resolve it locally to

prevent escalation. Where this was not possible the complaint was referred to the head of department or manager. All complaints resolved locally were recorded in a booklet and would be escalated further as required. Complaints were an agenda item on team meetings.

- The OPD received 14 complaints from January to June 2018. No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISACS).
- Senior managers were all involved in the management and investigation of patient complaints. The hospital acknowledged complaints within 48 hours of receiving the complaint, with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining the reason that additional time may be required for further investigation.
- Themes from complaints included complaints about charges and invoicing, unclear communication from consultants and car parking. Learning from financial related complaints included ensuring all hospital staff concerned with a patient's care and treatment, were transparent about costs involved. For example, a further x-ray or biopsy may be required that could elevate the initial fees. Posters were put on display throughout the OPD to remind patients that additional costs could be incurred, and to remind them to ask for clarification if they were not clear.
- Action had been taken to temporarily extend the car park whilst building work was completed however, and the hospital continued to encourage the use of car sharing.
- New complaints and learning from complaints were discussed at relevant committee meetings including monthly clinical governance team meetings, medical advisory committee meetings and heads of department meetings. Learning from complaints was cascaded to staff in the department in regular huddles and within team meetings.
- **See information under this sub-heading in the surgery report section.**

## Are outpatients services well-led?

Good

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

### Leadership

- **The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.**
- The service was part of the Ramsay Health Care UK group. The senior management team reported to the corporate leads and were supported through a network of regional and national leads and specialists.
- The hospital was led by a hospital director, a site operations manager, a finance manager and head of clinical services (matron). Heads of department or leads were in place for each specialty and service. At a department level staff reported to the heads of department, including the outpatients' and physiotherapy manager.
- All staff felt they could be open with colleagues and managers and told us they could raise concerns and would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.
- Departmental action plans gave ownership to heads of departments to ensure that objectives were cascaded to staff at all levels. Progress was regularly reviewed through the heads of department committee meeting and departmental meetings.
- Staff said the executive director and matron were well respected, and always available and supportive when required. Senior staff told us visibility of the senior management team was improving since a new local, rather than regional, general manager post was created.
- Managers encouraged learning and a culture of openness and transparency. They operated an 'open door policy' and encouraged staff to raise concerns directly with them. We saw senior managers visiting the outpatient's department during our inspection. Staff told us this was a normal occurrence.

- Senior staff were supported to attend corporate leadership programmes and additional training relevant to their role. Succession planning concerned the identification of staff with strong qualities to complete future leadership programmes.
- **See information under this sub-heading in the surgery report section.**

**Vision and strategy**

- **The hospital had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed.**
- The hospital had a vision statement which was to provide an outstanding service to patients and key stakeholders that was commercially sustainable, focused on future growth and delivered by a team who were proud to work at Rivers Hospital.
- The OPD and physiotherapy undertook audits of patient records, and infection, prevention and control that aimed to continuously improve patient care, in line with the hospital-wide vision and strategy.
- Staff were aware of the hospital vision in delivering high standards of care, and were aware of the strategy with 'growing' the service in areas, such as with the development of a radiotherapy unit in 2019. Staff were proud of the job they did and aimed to provide safe and high-quality care.
- **See information under this sub-heading in the surgery report section.**

**Culture**

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- We found the culture across the service aligned with the corporate culture, "Our Culture – The Ramsay Way". This set out statements concerning the organisation's cultural values that included:
- 'We are caring and progressive, enjoy our work and use a positive spirit to succeed'
- We aim to grow our business while maintaining sustainable levels of profitability, providing a basis for stakeholder loyalty'
- Working together - We believe that success comes through recognising and encouraging the value of people and teams'
- We build constructive relationships to achieve positive outcomes for all'
- We value integrity, credibility and respect for the individual'
- We believe that success comes through recognising and encouraging the value of people and teams'
- We take pride in our achievements and actively seek new ways of doing things better.'
- Staff described the culture at the hospital as being open and honest and felt they were listened to by senior managers.
- Many staff had worked in the organisation for many years and there was a high staff retention rate. Staff said they felt valued by managers and colleagues.
- The nursing team, consultants, physiotherapy team and administration team communicated well together and supported each other.
- We saw that the culture of all the areas we visited during our inspection centred on the needs and experiences of the patients. For example, if a mistake happened this was handled in a sensitive and open way.
- All staff we met were welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service. We observed staff practice and saw that they were polite and professional with all patients and families.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.

**Governance**

- **The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- The service had clear governance systems that ensured there were structures and processes of accountability to support the delivery of good quality services. The service reported directly to the senior leadership team with clear lines of escalation in place.
- Senior OPD staff attended meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Senior Management, Heads of Department (HoD), Clinical Governance Committee, and Infection, Prevention and Control Committee meetings. Minutes were descriptive

and were circulated to the wider team for information. There was a list of attendance and an action log to monitor progress against identified actions. Feedback from these meetings was provided to staff during team meetings.
- The HoDs met monthly and the minutes showed items discussed included complaints, clinical governance, audit results, and key departmental feedback. These meetings also shared staff experiences and information was shared back with staff in the departments.
- Staff members were clear on their objectives and understood how they contributed to the hospital success. Heads of departments identified training needs of staff through appraisal and supported training at the Ramsay Health Care UK Ltd group training academy.

**Managing risks, issues and performance**

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- We saw there was a risk assessment process in place and that identified risks were assessed using a standardised template which scored the risk as low, medium or high risk. The local risk registers were managed by the heads of departments who escalated risks to the senior leadership team. Senior staff spoken with had a good knowledge of what was currently on their local risk register. There were eight risks identified across the service that had not met the threshold for escalation to the hospital wide risk register. These included manual handling and blood borne virus protection. The risks were regularly reviewed and the OPD manager explained they would escalate the risks for review with the senior management team if they could not be maintained. This was an improvement on the June/July 2016 inspection when it was not clear how risks identified in the outpatient's departments were included in the hospital's overall risk register.
- The risk register was discussed as part of the service performance review meeting. Staff described their understanding of what constituted as a risk and were confident they would raise any concerns that they believed impacted on safe patient care.
- The service manager had systems and processes which supported monitoring of performance and issues. We observed they had access to an online system to monitor for example; training compliance and equipment maintenance.
- Any performance issues or concerns were escalated through monthly departmental review meetings held between the HoDs, clinical lead, hospital director and finance director.
- There was a programme of internal audits used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Senior staff confirmed results were shared at relevant meetings such as clinical governance meetings.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS) and Patient Led Assessment of the Environment (PLACE).
- **See information under this sub-heading in the surgery report.**

**Managing Information**

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Relevant staff could access NHS and private patient electronic records appropriate to the needs of the investigation being completed.
- Computers were password protected and locked when not in use. We saw that computers were not accessible to patients.
- **See information under this sub-heading in the Surgery report section.**

**Engagement**

- An employee innovation group included representatives across all departments to drive the employee action plan from the staff engagement survey. The employee group worked with the senior management team and staff by holding regular forums to ensure staff were kept informed and had the opportunity to ask questions. Senior staff said they passed information from the team to their staff through daily huddles.
- The hospital had engaged with its patients and had created a patient's charter. The charter outlined 'the hospital's:
  - Commitment to the patient,
  - Care delivered in privacy, with compassion, dignity and respect.
  - Care in a safe and clean environment, and

  - By a friendly, efficient team who ensured involvement in decisions about treatment while aiming to promote your independence.'
- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. We saw there were boxes throughout the hospital to place completed forms. The hospital also gathered patient opinion from the friends and family test (FFT), and patient led assessment of the care environment (PLACE). Departments used the results of the survey to improve the service. Patient could also post feedback on-line on NHS choices and social media sites.
- Staff recognition schemes included service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years.

**Learning, continuous improvement and innovation**

- The OPD service took on board feedback following the previous inspection in June/July 2016. For example, there was a clear process for risks identified in the OPD to be included in the hospital's overall risk register. OPD leads were knowledgeable about the risk assessment process and of when a risk required escalation for further review.
- Since the June/July 2016 inspection, the OPD had appointed two qualified registered sick children's nurses (RSCNs) during 2018 to support children attending outpatient appointments.
- The level of activity carried out which meant that staff were unable to ensure patients' comfort. Plans for the redesign of the radiology service continued, which it was hoped would provide additional space for use by the OPD. Not all clinical wash basins in the outpatient departments complied with the Health Building Note (HBN) 00-09 however, mitigating action was taken to minimise risks. The review of the car parking space continued and temporary spaces were made available when possible.
- There was a culture of continuous staff development across the departments. We heard of examples of staff being supported to complete a range of qualifications including a physiotherapy technician course; a cognitive behavioural therapy for pain management course; and leadership courses.
- 'Speaking up for Safety' training programme was an addition to staff training in July 2018, and 45% of staff across the hospital had participated in the programme. Some staff told us the training encouraged staff to challenge anyone, including senior colleagues, who may be putting patients at risk with their behaviour.
- The corporate Ramsay Health Care UK Ltd group awards had been introduced during May 2018, and the physiotherapy team won an award for their contribution to improved patient outcomes.
- In recognition of staff and departmental achievements, a senior staff member from the OPD was awarded 'employee of the month', and the OPD as department of the month in October 2018.
- Funding had recently been approved to update the physiotherapy gym equipment.

Good

# Diagnostic imaging

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

## Information about the service

The diagnostic imaging service sees both adults and children and young people. The hospital also accepts referrals from their sister hospitals within the Ramsay eastern region for their computed tomography (CT) (a series of x-ray images taken from different angles around the body) and magnetic resonance imaging (MRI) (a technique used to form pictures of the anatomy and the physiological processes of the body) and mammography services.

The diagnostic imaging service was refurbished and upgraded at the beginning of 2017. The services provided by the hospital include x-ray, ultrasound, computed tomography (CT) (a series of x-ray images taken from different angles around the body) and magnetic resonance imaging (MRI) (a technique used to form pictures of the anatomy and the physiological processes of the body) scanning facilities, mammography and dual energy x-ray absorptiometry (DEXA) scanning. A DEXA scan is a type of x-ray that measures bone mineral density.

During the inspection, we visited the radiology service. We spoke with eight staff including; radiographers, health care assistants, reception staff, radiologists, and senior managers. We spoke with six patients and one relative. We also reviewed four sets of patient records. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

### Are diagnostic imaging services safe?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

**Mandatory training**

- **The service provided mandatory training in key skills to all staff. There were processes in place to monitor compliance and ensure everyone completed it.**
- The hospital delivered a mandatory training programme internally for all staff members including clinical and non-clinical. Staff attendance was recorded to ensure compliance and the training facilitated monthly. The hospital business plan for 2018/19 identified that one of the actions was to improve training rates to 90% by the end of the year (April 2019). The hospital had a mandatory training tracker for 27 courses which included both practical and e-learning.
- Mandatory training courses in key skills was provided to staff, which included “face to face” and “e-learning” training modules. Mandatory training topics covered key areas such as basic life support, manual handling, health and safety and infection control.

Good

# Diagnostic imaging

- The mandatory training tracker for October 2018 showed an overall rate for the hospital of 85% which included for example, hand hygiene and immediate life support. The diagnostic imaging service had achieved a training figure of 70%. Senior staff confirmed there had been issues with the e-learning system with radiographers not being able to access the system due to the unavailability of passwords. This problem had been resolved and we saw evidence of a training schedule for staff to complete any outstanding training. The manager had access to the electronic training record, which detailed all staffs training compliance.
- Staff confirmed they often could not complete their training due to the service being busy but were complimentary about being allowed to complete their training at home. Staff confirmed they found this beneficial and said it did not encroach on their work life balance.
- All staff undertook mandatory annual e-learning and practical training sessions for infection prevention and the consultant microbiologist provided bi-annual in-house training. We saw evidence that radiographers had read the local rules, employer's procedures and had received training on radiation risk where appropriate.
- The consultant radiologists, working for the hospital under practising privileges, did not receive mandatory training from the service. They received training from their substantive place of employment and Rivers Hospital kept a record of their completed training. Practising privileges is an established process within independent healthcare where a consultant radiologist is granted permission to work in an independent hospital in the range of services they are competent to perform.
- **Full details of training compliance across the hospital can be found within the surgery report.**

**Safeguarding**

- **Staff understood how to protect patients from abuse and knew how to recognise and report abuse.**
- Safeguarding adults and children's policies seen had been reviewed and were up to date. They reflected relevant legislation and local requirements, including the contact details of the local safeguarding boards. Contact numbers for making safeguarding referrals were also displayed throughout the service.
- Rivers Hospital ensured they were compliant with the required standards for safeguarding children and young people and delivered training and competences for all staff in line with the Royal College of Paediatrics and Child Health 2014 safeguarding intercollegiate document and Ramsay policy. These documents specified the levels of training required for the appropriate staff roles. The hospital had a mandatory training tracker to review its safeguarding training for both adult and children and young people. The quality account for 2017/18 identified the following:
  - 95% of all staff were trained to level 1.
  - 96% of identified staff were trained to level 2.
  - 99% of identified staff were trained to level 3.
- Staff spoken with were aware of safeguarding procedures but confirmed they had limited experience of managing concerns due to their brief contact with patients, their relatives or carers. Staff told us that if they were concerned about a patient, they would contact the head of department or head of clinical services (matron) for advice.
- The diagnostic imaging service had access to children's nurses when they attended the service. All paediatric nurses, the head of clinical services and head of departments had level 3 safeguarding training. Key staff directly involved in children's care were trained to level 3 which included radiographers. The service monitored staff training monthly identifying those that were due to update their training. All new staff had to complete safeguarding training on starting before they were cleared to be involved in the care of children and young persons.
- All children under the age of 16 years received direct care from a registered children's nurse. In radiology/ imaging service they were available to chaperone and support the child and their parents/carers. The nurses also ensured that parent and child and young person information was readily available to inform them on what to expect. The children's nurses were trained to children's safeguarding level 3.
- Radiographers told us that should they suspect physical abuse when reporting images, they would escalate their concerns to their manager or senior management team.
- Prevent is one of the arms of the government's anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. Prevent training formed part of the wider safeguarding agenda and encouraged staff to

view a patient's vulnerability as they would any other safeguarding issue. Training figures across the diagnostic service showed that 92% of diagnostic staff had completed their training as of December 2018.

- Staff's awareness of female genital mutilation (FGM) was carried out alongside their level 2 adult safeguarding training. Staff spoken with showed good recognition of FGM. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Staff said that should they have any concerns they would contact the head of department or head of clinical services.
- **Full details of training compliance can be found within the surgery report.**

**Cleanliness, infection control and hygiene**

- **The service controlled infection risk well. Although the premises and environments appeared clean, we saw that cleaning schedules were not always completed which meant that we could not be assured that areas had been appropriately cleaned.**
- The hospital's infection control processes were coordinated and led by the infection prevention and control (IPC) nurse. The IPC committee comprised of a consultant microbiologist, IPC lead, head of clinical services, pharmacy link and theatre manager. The minutes identified representation and links from the x-ray department. Meetings were held quarterly and provided the hospital with infection prevention advice and guidance in conjunction with Ramsay Health Care infection prevention and control policies and procedures and national guidance.
- We saw the infection prevention and control team meeting minutes for May and September 2018. These were well laid out and included the outcomes of previous actions, training and audit results and a review of incidents.
- Infections were reported onto the hospital's electronic system which was reviewed quarterly at the prevention meeting and clinical governance meetings. Root cause analyses were carried out on all serious cases of infection according to the criteria outlined in the Health Care Acquired Infection (HCAI) Surveillance Policy IPC-14 (2015).
- Domestic cleaning was completed by the hospital housekeeping staff who prioritised treatment areas for cleaning. The September 2018 infection prevention and control meeting minutes identified that cleaning schedules were difficult to get signed. During the inspection we found that cleaning schedules were not always signed. For example; we saw five days in December 2018 which had not been signed. Senior staff confirmed they were aware of the shortfall and said they would continue to address the matter with staff. We saw cleaning schedules had been included in team meeting minutes seen. Patients and relatives spoken with said they found the departments to be clean and tidy each time they visited.
- The hospital had implemented new hand hygiene dispensers and 'bus stop' hand gel stations which we saw in place. Hand gel dispensers were available in waiting areas with visible signage to encourage staff and visitors to use them. During the inspection, we did not observe any patient or visitor use the hand gel dispensers and staff did not encourage visitors in their use.
- All consulting and imaging rooms we inspected had hand-washing facilities, antibacterial hand gel, paper towels, and cleaning wipes available. We saw posters displaying the World Health Organisation's 'five moments for hand hygiene.' Staff were observed washing their hands before and after each patient's appointment and patients confirmed that they observed this. We saw the hospital wide hand hygiene audit results for July 2018. This was based on 10 observations and covered areas such as hand decontamination, hand washing techniques and compliance to policy. The average results were 95%. However, it was noted that the radiology service was not included in the audit results. This was discussed with senior management who confirmed this to be an oversight as they believed the audit was being completed by the IPC team. Senior staff immediately put processes in place for the radiology department to complete hand hygiene audits. The imaging service provided us with the hand hygiene audit figures for December 2018 which showed an achievement score of 90%. We found no issues of concerns with hand hygiene processes during the inspection.
- All members of staff were required to undertake a hand cleanliness inspection. The inspection was carried out by all heads of departments with a visual inspection carried out by the IPC nurse at mandatory training days

annually. All new staff had their hands checked when they started employment. The annual Rivers Hospital infection control committee report for 2017/18 showed 97% compliance.

- The service trialled the use of an electronic ultrasound probe decontamination system in 2016 and Rivers Hospital was the first to use the service. The system ensured probes were cleaned under a process which allowed the objects to be completely free from microorganisms including viruses. Staff spoken with confirmed this maintained a high standard of infection prevention for patients. Due to the success of the trial the decontamination system was being rolled out across other hospitals within the Ramsay Health Care UK group of hospitals. Staff were proud of the system and confirmed they were providing training to their colleagues at other hospitals.
- Equipment was cleaned after each use to ensure it was ready for the next patient. We observed the ultrasound being cleaned after each procedure and the couch was prepared for the next patient with clean paper.
- Clinical waste was sorted and disposed of in appropriate, foot-operated waste bins. Sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste.

**Environment and equipment**

- **The service had suitable premises and equipment and looked after them well.**
- There was a radiation protection policy which was regularly reviewed and the radiation protection officer carried out audits that demonstrated compliance with the Ionising Radiation Regulations 2017 (IRR 17).
- The hospital had invested in new equipment in radiology and refurbished the screening rooms. The services provided included x-rays, ultrasound, CT and MRI scanning facilities, mammography and dual energy x-ray absorptiometry (DEXA) scanning. A DEXA scan is a type of x-ray that measures bone mineral density.
- The Rivers Hospital was reviewing proposals to expand radiology and the Thomas Rivers area due to limitations with space. The x-ray reception area had a small waiting area with limited flow due to the size of the department. The hospital was preparing a proposal for a new MRI scanner and mammogram in 2019. They were in discussions with a third party on a proposal for radiotherapy services and would upgrade their scanners once this had been confirmed.
- Records showed electrical equipment in the departments had been portable electrical appliance tested and that radiology and other equipment was serviced regularly under contractual arrangements with the suppliers.
- Patients attending the department reported initially to the reception area where they were either directed to the CT and/or MRI department or waited in the x-ray waiting area. A member of the diagnostic team then called the patient into the department for their investigation.
- We saw evidence that quality assurance testing was completed at regular intervals in line with the Institute of Physics and Medical Engineering (IPEM). We saw the annual report for 2018 with no issues or concerns identified.
- The x-ray service used the resuscitation trolley located in the outpatient's department while the CT and MRI areas had access to their own resuscitation trolley. The anaphylaxis (an acute allergic reaction) boxes which staff accessed in an emergency, were available and in date. These were well equipped and maintained, with daily checks recorded. We found no issues or concerns with the daily or weekly checklist recordings.
- We saw that all imaging rooms were clearly signposted with "do not enter" warning lights to ensure that staff or patients did not enter rooms whilst imaging was taking place. This was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance for access.
- Staff had access to appropriate personal protection equipment (PPE), including lead gowns and neck shields. The radiology department had clear guidelines on which specialised PPE should be used for specific procedures. PPE was routinely checked to ensure it was not damaged. Staff also wore radiation exposure devices which were analysed to ensure that staff were not over exposed.
- The service stored hazardous substances appropriately and in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health. We saw up to date COSHH risk assessments to support staff's exposure to hazardous substances.

**Assessing and responding to patient risk**

Good

# Diagnostic imaging

- **Staff assessed risks to patients so they were supported to stay safe.**
- We saw policies in place to support staff in their role in responding to patient risk. For example; the head of department had up to date files in line with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 17) procedures, as well as standard operating procedures as required under the regulations.
- The service had a designated radiation protection supervisor (RPS) which was in line with the Ionising Radiation Regulations 2017 (IRR17). The RPS's role ensured the service's adherence to safe working practices and what actions to take in an emergency.
- Local rules as required under IRR17 required employers to keep exposure to ionising radiation dosage as low as reasonably practicable. The purpose of the local rules was to assist the RPS in instructing staff in radiation protection, and, in the event of an accident, to provide a clear reference to prepared contingency plans.
- The radiology department displayed the local diagnostic reference levels (DRLs) for the service. DRLs are intended for use in identifying the level of patient doses. These levels are expected not to exceed the diagnostic examinations being carried out.
- All staff wore radiation badges to monitor any occupational doses. The service was compliant with the assessment and the recording of radiation doses as recommended under IRR17.
- There were signs in the radiology department to denote where radiation exposure occurred to ensure that patients and staff only entered when it was safe to do so.
- Senior staff from the diagnostic service attended the daily "ten at ten" meeting which provided the opportunity to discuss any concerns which included for example; planned activities, staffing issues and any equipment or maintenance concerns. Feedback from the meeting was discussed with staff which ensured they could assess and respond to patient risk as appropriate.
- Most patients attending the imaging department were fit and mobile. Those patients that were unwell, were usually inpatients and accompanied by a ward nurse, and if necessary the resident medical officer (RMO). Most patient risk was completed by the pre-admission service or the referring consultant. However, the radiology service routinely assessed the risk the investigation posed when the patient attended their appointment.
- Patients attending the imaging service were required to complete an extensive checklist prior to the investigation to ensure that all risks had been identified to reduce any potential consequential harm.
- Imaging staff were aware of the need to risk assess patients prior to each investigation and knew how to escalate any concerns they may have. There were standardised processes to assess risk used within each modality, based on national guidance. For example, the form used to refer patients to the radiology department included a safety check to ensure there was no risk that the patient might be pregnant before undergoing radiation exposure. There were also signs around the radiology department to alert female patients of childbearing age to tell staff if they might be pregnant. Radiographic imaging and MRI during pregnancy might cause harm to the developing foetus and we saw a checklist which was used to assess any potentially pregnant patient prior to the investigation being completed.
- Staff in the radiology department used patient pathways and the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) safety checklist for patients undergoing interventional radiology and scans to ensure that the right patient got the right scan or procedure at the right time. We reviewed four sets of notes for patients who had attended the radiology department and found that checklists had been appropriately completed and recorded.
- We saw that children's nurses were available to support children for procedures such as indirect arthrogram (an image to evaluate conditions of joints). The children's nurse remained with the patient throughout the procedure.
- The service completed a safety briefing/debrief for interventional procedures. This included both a pre-list and post list briefing. Discussions included areas such as; what surgical/imaging equipment was required and if it was available, patient risk and was the safety checklist fully completed for each patient.
- The safer surgery October 2018 audit was based on the observation of 10 invasive interventional procedure list. The findings ranged from 70% to 100%. For example;

- All relevant team members were present for the "sign in" (100%) but only 70% were present for the "sign out."
- All areas requiring times, initials and signatures were recorded and legible (70%).

- The audit had an action plan attached which included the continuance of monitoring to ensure compliance. We saw folders within the staff room which included details of audits carried out and both the manager and radiographers confirmed they reviewed and discussed the results at team meetings.
- Investigations were requested using a paper referral system, which was signed by the consultant, and detailed the patient's demographics and outlined the investigation requested. This referral card was used by imaging staff to confirm the patient's identity when attending for their investigation.
- Referrals were reviewed by imaging staff to ensure that the correct procedure was being requested. To safeguard the patient, a search was completed of the database to identify if the investigation had been completed at an alternative location. This process prevented patients being exposed to radiation unnecessarily. Radiographers told us that they would enquire with the referring consultant if they had any queries or concerns regarding the requested procedure.
- Patients were asked to confirm identity prior to an investigation being completed. Information relating to the patient's name, address, date of birth and expected investigation was discussed between the patient and the member of staff looking after them.
- The MRI and CT waiting area on the lower ground floor did not have a reception desk. Patients were required to ring the bell to get the attention of a member of staff when they arrived in the scanning department, or if they felt unwell while waiting before or after their scan. This was identified as an area of concern during the June 2016 inspection. During this inspection, we observed that staff did not always respond to the bell immediately and this continued to put patients at risk as they could not always be observed by staff while in the waiting area.
- Staff checked that patients who required a contrast media were not allergic prior to administration. Contrast media is used to increase the differences of structures or fluid within the body and was administered by the radiologist responsible for the patient.
- Following investigations, images were reported by a radiologist except for dental images and those taken during surgical procedures. When the consultant would review the image. The service had designated reporting staff each day which meant delays were avoided.
- The service could access the image exchange portal (IEP) for the safe and secure transfer of picture archiving and communication system (PACS) held images across a national network. The service could "blue-light" any request to receive prioritisation of information if required.

**Radiology staffing**

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- The hospital had an electronic rostering management system that enabled managers to effectively manage rotas, staffing requirements, skill mix and senior cover. The imaging service ensured they had appropriately trained imaging staff to maintain patient safety.
- The service monitored the staffing levels daily and weekly to ensure there were safe staffing levels to meet the number of patients seen and to ensure the service manged their individual needs. The total staff mix for the diagnostic imaging service was 70% qualified and 30% non-qualified.
- The recruitment and retention of radiographers was on the hospital's risk register. The service had put in place control measures which included the use of bank and agency staff. Senior staff confirmed they were actively trying to recruit staff through a recruitment campaign as well as trying to recruit bank staff.
- Senior staff confirmed they were currently using agency staff to cover any shortfall in shifts. They said they block booked radiographers to maintain continuity within the service which was confirmed by agency staff spoken with.
- The imaging service flexed their time to cover the needs of patients attending the service. Staff confirmed they could call on the services of the resident medical officer when required. Bank and agency nurses used were familiar with the service. This ensured that radiographers met key requirements such as having completed mandatory training.
- **See additional information under this sub-heading in the Surgery Report section.**

Good

# Diagnostic imaging

**Medical staffing**

- **The service had enough radiologists with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- There were no radiologists employed directly by the service, with all radiologists working under practising privileges. All radiologists carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Radiologists new to the hospital received a formal induction, and could work under practising privileges only for their scope of practice covered within their NHS work.
- All consultants were requested to provide documented evidence of an annual appraisal so that it could be used as part of their revalidation process.
- The service had 16 radiologists working within the hospital. For radiologists to acquire and maintain practising privileges radiologists were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development.
- There was a small group of radiologists working within the service to facilitate reporting on images. These were regular staff, who attended the hospital on set days according to their availability. Staff told us that if their specialist knowledge was required, they could be contacted directly.
- **Details of radiologists working at the hospital can be found in the surgery report.**

**Records**

- **Staff keep appropriate records of patients' care and treatment. Records were kept in locked cupboards and were only accessible to authorised staff, to maintain confidentiality.**
- The radiology records audit for August 2018 showed the service had achieved an overall score of 96%. The audit was based on 20 or 30 records dependent on the category which included; referral information, MRI patient safety, the review of records using ionising radiation and contrast media and medicine management. However, one category audited, the "referral form contraindications completed by the referrer" scored 50% (10 from 20 records) and another the MRI patient weight and height recorded by the radiographer scored 65%. The audit had an action plan which included:
  - Manager to discuss with referrers.
  - A re-audit in January 2019 to monitor improvement.
  - Discuss at team meetings.
- We saw a team meeting minutes folder in the staff room which identified that the above concerns had been discussed.
- We saw the request form audit for December 2018 which was based on the review of 155 requests for diagnostic imaging services. This included the patient's name, address, reason for x-ray and body location. The results where are follows:
  - Name 72%, Address 67%, Date of birth 72%.
  - Reason for x-ray 14%.
  - Body part 26%.
- We saw an action plan to address the low scores. The audit identified that of the two lowest scores the information had been completed but not ticked to say they had been checked. Staff confirmed this had been addressed in their team meeting which was identified in the minutes seen. A re-audit was due to be carried out in February 2019 to review the findings.
- Diagnostic images were archived using an electronic database and were password protected to prevent unauthorised access. Images could be shared with external systems if necessary which was useful when a specialist opinion was required.
- Computers were locked when not in use. This prevented unauthorised access and protected patients' confidential information.
- We looked at four patient records which we found to be well maintained. Entries were dated and signed by the appropriate staff member which included details of all investigations and their findings.
- The service could access an image exchange portal which allowed them to exchange imaging information with other colleagues which included other providers and consultants. The service could "blue-light" any request to receive prioritisation of information if required.

**Medicines**

- **The service gave, and recorded administered medicines well.**

Good

# Diagnostic imaging

- The imaging department used a small number of medicines for investigations. These were largely contrast media. We saw these were stored in locked cupboards within the diagnostic imaging service.
- Radiologists were responsible for the prescribing all medicines for patients attending the service. Radiographers with the appropriate skills and competence were responsible for administering medicines required for imaging.
- During the inspection we found most medicines were in date. However, we found alcohol wipes which were out of date. These were immediately replaced and others in the department checked.
- **Detailed findings on medicines can be found in the surgery report.**

**Incidents**

- **Safety incidents were managed in line with best practice. Most staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**
- There was a Ramsay Healthcare group policy for incident reporting, which was in date. The policy identified everyone's responsibilities for reporting and investigating incidents. Staff described when they would report an incident and the process used. Incidents were investigated and discussed during staff meetings. We saw minutes of meetings that confirmed this.
- There were no never events or serious incidents reported in the diagnostics department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The incident feedback shared learning group reviewed all incidents across the hospital. The hospital's strategy for 2018/19 identified the continuation of shared learning through audits, incidents and adverse events and complaints. The hospital introduced lessons learned session for 2017/18 whereby staff across the hospital could attend. The hospital confirmed these would continue to run for 2018/19 to ensure that shared learning from significant events and preventing similar incidents happening in the future.
- All incidents involving radiation were reported on the hospital's incident reporting system. These were categorised as 'IR(ME)R' incidents for data collection and trend monitoring. The hospital reported all radiation errors to the radiation protection advisor. Senior staff and radiographers explained and demonstrated the processes to be followed for radiation incidents.
- There had been three radiation incidents within the diagnostic service from August 2017 to July 2018 of which one was reportable under IRR17 regulations. We saw the report had been fully investigated with outcomes discussed and recorded at team meetings. Radiographers spoken with were aware of the incident and could describe processes in place which included the additional checking of a patient's previous exposure to radiation.
- The evidence provided by the hospital showed there had been 182 clinical incidents and no non-clinical incidents attributed to the outpatients and diagnostic imaging services from July 2017 to June 2018. We did not see how many incidents were attributed to the radiology department but the manager had oversight of all incidents. There were no identified themes but radiographers informed us the service had implemented an additional checking system to ensure that all picture archiving and communication system (PACS) (a system to store and digitally transmit electronic images and clinically-relevant reports) were accounted for and had the correct information attached to reduce information governance incidents.
- From November 2014, hospitals were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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 the person.
- The hospital had a "being open" policy which provided guidance for staff when patients were involved in an incident by ensuring that, if a mistake was made, patients and/or their relatives/carers received promptly the information they needed to enable them to understand what happened. Radiographers spoken with understood their responsibilities regarding the duty of candour legislation. They said they were open and

honest with patients and applied this to all their interactions. Radiographers said they would discuss any identified concerns with the patient and provide a full apology.

**Safety Alerts**

- **The service planned for emergencies and staff understood their roles if one should happen.**
- National patient safety alerts when received were circulated through either an email or hard copy to each head of department who confirmed any action undertaken and signed off once completed. On completion the central alerting system database was updated. The hospital confirmed they were up to date with all safety alerts.
- We observed, during the inspection, staff timely responding to an emergency within the x-ray waiting room. All staff responded effectively with each other and knew what action to take in response to the emergency.
- **See information under this sub-heading in the Surgery report section.**

## Are diagnostic imaging services effective?

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously inspected but not rated. We currently do not rate effective for Diagnostic Services.

**Evidence-based care and treatment**

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.**
- Policies, procedures and protocols seen to manage patient's safety were up to date. Policies were referenced against national guidance to ensure care and treatment was delivered in line with legislation, standards and evidence based guidance.
- The service worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017 (IRR17) and guidelines from the National Institute of Care Excellence (NICE), the Royal College of Radiologists (RCR) and other national bodies. This included all specialities within diagnostics. We saw the service had an action plan to ensure they were compliant with IRR17. Areas included; shared dose information, local procedure for referrals, training updates and copy of national diagnostic reference levels (DRLs).
- There were systems to ensure that the radiology department complied with DRLs. Staff showed us audits of these which demonstrated that radiation doses to patients were kept as low as reasonably practicable.
- There was a defined audit schedule which the service completed and audited regularly. These covered topics such as record keeping and care of the environment. Most staff were aware of the results for their areas and could tell us about measures the service had undertaken to improve compliance. Staff referred us to folders within the staff room which highlighted evidence of audits and their results.
- Rivers Hospital had adopted and implemented the National Safety Standards for Invasive Procedures (NatSSIPs). A NatSSIP supports the hospital to provide safer care and reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur. We saw the radiology departments and its staff had developed and embedded local NatSSIPs to evidence safe practice and reinforce patient safety.

**Nutrition and hydration**

- **Patients had access to a drink when visiting the service.**
- Patients were provided with clear instructions in their preparation letter about the amount of fluid to drink prior to attending the imaging department. If patients had to fast, they had access to a water fountain in reception to quench their thirst after their procedure.
- Patients were given a drink and a biscuit after their intervention procedure. We observed staff checking on patients to ensure they were safe to leave the hospital after their procedure.
- See information under this sub-heading in the surgery report section.

**Pain relief**

- **The service managed patients' pain effectively.**
- We observed staff asking patients if they were comfortable during their procedure for example; ultrasound scans.

- If patients required pain relief while in the departments it was prescribed by the radiologist or resident medical officer (RMO) and administered by a radiographer. Staff told us that the need for pain relief in the departments was very rare.
- See information under this sub-heading in the surgery report section.

**Patient outcomes**

- **The service monitored the effectiveness of care and treatment and consistently used the findings to improve them.**
- The magnetic resonance imaging (MRI) and computerised tomography (CT) audits for September 2018 were based on private patients. There had been a total of 188 MRI scans performed during this period of which 20 were randomly selected and 118 CT scans of which 13 were randomly selected. Areas looked at included; images quality, clinical opinion and language of the report. The audits were RAG (red, amber, green) rated and had achieved 100% compliance.
- The imaging service had completed audits in line with their local NatSIPPS, the Royal College of Radiologists (RCR) and IRR17 regulations. The October 2018 audit showed the following results:
  - intravenous cannulation competency (100%).
  - CT Colonography (CTC) radiographer's competency (100%).
  - MRI safety which included; cleaning, local rules and patient evacuation procedure (100%).
- The radiology manager reviewed the process for the recording of patients who did not attend appointments (DNA's) and turnaround times to ensure that they were meeting Ramsay targets. We found no issues or concerns from the October 2018 NatSSIP audit regarding DNA figures and turnaround times.
- The service used the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) safety checklists for all interventional imaging. We saw the checklist audit for October and November 2018 which identified 100% compliance. Completed forms, were scanned into the individual patient's records and saved on the radiology information system.
- The non-radiologist reporting audit and the non-radiologist image reports for September 2018 were based on 10 randomly selected patient records where a radiologist report was not required. Areas covered included; evaluation taken within seven days of examination and examination/procedure stated as well as the images on PACS to ensure they were kept securely. The service scored an average of 98% and 95% respectively.
- The annual diagnostic radiology and radiation committee report for May 2018 regarding diagnostic x-ray equipment performance and radiation safety reported no issues or concerns.
- **See information under this sub-heading in the Surgery Report section.**

**Competent staff**

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance.**
- The manager monitored staff's competence. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and one to one meetings.
- Staff had attended additional training relevant to their role. The 2017/18 training data showed that members of staff within the radiology services had attended both local and external courses and well as courses provided by the Ramsay academy. These included; dealing with difficult people, effective leadership skills and automated external defibrillator (AED) training. AED training ensured staff have the necessary skills needed to respond to an emergency until medical services arrived.
- The radiation protection supervisor (RPS) received training every five years from the radiation protection advisor's organisation. We saw dates had been approved for 2019 for RPS basic training days.
- All staff administering radiation were appropriately trained to do so. Those staff that were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R 2017.
- We saw evidence that all radiographers had in date health care professional registration (HCPC). This was in line with the society of radiographers' recommendation that radiology service managers ensure all staff are appropriately registered. Training specific to their registration was reviewed during staff appraisals, along with any development plans.

- Staff confirmed the hospital supported staff training and development with staff apprenticeships, mentorship and preceptorship. Staff said they could request external training courses with training being approved specific to individual's development plans and scopes of practice. Staff confirmed there was good access to additional training and found the hospital very proactive in encouraging staff to attend additional training.
- The manager confirmed they had assessed staff to ensure they were competent in their role. We saw a competency folder in place which meant staff had been appropriately assessed.
- Newly appointed radiographers underwent assessments of their competency and we saw completed records maintained by the radiology department manager.
- Senior management told us that radiologists applying for practising privileges had to demonstrate their competency prior to carrying out procedures in radiology. Staff also said that any existing radiologist wishing to undertake new procedures had to demonstrate competency. This was done by reference to their NHS practice.

Appraisal

- All imaging staff received an annual appraisal. This enabled senior staff to review each staff's individual needs and ensured staff had adequate development to support their role. Any additional training needs were discussed as part of the appraisal process and learning needs agreed with timescales. Data seen during the inspection showed that 100% of staff had received their annual appraisal. Staff spoken with confirmed they had received their appraisal which they found beneficial and supported them in their role.
- The head of department monitored staff's ability and provided on-site training if necessary, using appraisals and supervision to support and develop staff. Any additional training needs were discussed as part of the appraisal process and learning needs agreed with timescales.
- Staff received a comprehensive induction and support specialist training when they started work at the hospital to improve competence, skills and confidence. This included a hospital wide induction and local induction. The local induction included orientation to the area and local competencies. The hospital wide induction included information governance, infection prevention and control and fire safety. Staff said they found the inductions helpful.

**Multidisciplinary working**

- **Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- We saw that the imaging team worked closely with the visiting radiologists. Multidisciplinary team (MDT) meetings were not undertaken within radiology with the majority of discussions being completed at the local acute hospital trust. The exception to this was private urology patients who were discussed on site. Senior staff confirmed they were informed of any feedback as required based on the patient's individual needs.
- Staff told us that they could contact their peers working across the Ramsay hospital group for support and advice when required. Heads of departments met to share ideas and work together on consistent approaches to the delivery of care across the Ramsay group.
- A radiologist attended the medical advisory committee and local departmental meetings.
- **For detailed findings on multidisciplinary working please see the effective section of the surgery report.**

**Seven-day services**

- **There was a six-day service provided by the imaging service with an on-call provision for any urgent referrals.**
- The imaging department provided a service every Monday to Friday 8:30am to 8pm and Saturday 8:30am to 1pm. Outside these hours, imaging could be obtained through an on-call system.
- The priority clinical standards for seven-day hospital service identified that under standard 5 hospitals must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography and microbiology. All patients could access diagnostic services seven days a week using the on-call team and CT and MRI out of hours could be requested by a consultant.

Good

# Diagnostic imaging

- There was an on-call rota for the on-call radiologists and radiographers for out of hour's requirements. A weekly on call rota was circulated, including details for all clinical areas and an on-call member of the senior leadership team. Each department had a radiologist directory which included contact details. Radiographers details could also be accessed electronically on the hospital's shared electronic information system.
- The resident medical officer (RMO) was available seven days a week. The RMO liaised with consultants as to the provision of care for patients when they were not in the hospital.

**Health promotion**

- **Staff supported patients to manage their own health, care and well-being as appropriate.**
- **See information under this sub-heading in the surgery report section.**

**Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)**

- **Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients who lacked the capacity to make decisions about their care.**
- The Mental Capacity Act (MCA) protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.
- The hospital had an up to date policy regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff could access this on the hospital intranet.
- Patients attending the imaging department were required to give consent for their procedure. This was usually in the format of verbal consent for investigations such as x-rays.
- The radiologist responsible for an invasive investigation obtained consent from the patient following a detailed account of the investigation process. We did not see any of these procedures during the inspection, and therefore we were unable to confirm the consent practice was being completed appropriately.
- Where the child or young person was too young to confirm identification details or understand the examination being undertaken, radiographers sought the consent from a responsible adult. This would be either a parent, guardian or other health care professional for the child or young person at that time.
- The consent audit for November 2018 showed the imaging service had achieved 100% compliance. Examples of areas covered included; details correctly completed on the consent form, all risk described in a language that the patient could understand and patients had signed and dated the form.
- **See information under this sub-heading in the surgery report section.**

## Are diagnostic imaging services caring?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

**Compassionate care**

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed imaging staff caring for patients with compassion and understanding. We saw that all staff introduced themselves to patients, gave details of their name and ensured that they knew what they were attending the department for.
- Staff promoted privacy, and patients were treated with dignity and respect. Patients were called from the waiting room and staff used this time to talk to patients and put them at ease. We observed staff talking to patients in a respectful and considerate way. For example, we saw both administration staff and radiographers responding compassionately to a patient's emotional distress when attending the service.
- Rivers Hospital focussed on patient feedback to gather data from patients about their experience and satisfaction with the services they have received. Data seen showed that 97% of private patients within the radiology service were satisfied with the service

provided and 96% of patients responded via the NHS friends and family test. However, the figures did not identify how many patient returns had been received. During the inspection we observed that staff did not routinely ask patients to provide feedback during their visit to the department and we saw no evidence of feedback forms for patients, their relatives or friends to complete.

- Six of the eight patients spoken with confirmed they had not been given the opportunity to provide feedback on the service. However, patients told us they would be happy for their friends and family to come to the hospital for treatment.

**Emotional support**

- **Staff provided emotional support to patients to minimise their distress.**
- Staff showed awareness of the emotional and social impact that a person's care, treatment or condition would have on their well-being.
- Staff understood the emotional stress of patients having a procedure. Imaging staff were not routinely involved with providing support for specific illnesses, but could refer patients to their consultant or the head of clinical services if they felt that additional support was required.
- Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "I love the hospital and can't fault the staff" and others said staff were "very friendly" and "always available to answer any concerns."

**Understanding and involvement of patients and those close to them**

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients said they felt involved with decisions about their care and treatment and had been asked for permission and agreement which meant that the views and preferences of patients were considered. Radiologists and radiographers gave advice regarding investigation reports and explained that they would need to see the referring consultant for further information.
- Patients and relatives confirmed they had been given the opportunity to speak with the consultant looking after them. Patients said the consultants had "explained everything" and that they were fully aware of what was happening. All patients were complimentary about the way they had been treated by staff. We observed staff introduced themselves to patients, and explained to patients and their relatives about the care and treatment options.
- Patients who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

## Are diagnostic imaging services responsive?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

**Service delivery to meet the needs of local people**

- **The service planned and provided services in a way that met the needs of local people.**
- Patients attending the hospital's imaging services were a mix of privately funded and NHS funded patients (these patients had chosen the hospital as a location for their appointment through the NHS e-referral service). This meant that there were several patients who attended the service for an investigation without a private consultation.
- Radiology and scanning services were clearly signposted and staff directed patients to the relevant areas.
- The radiology departments offered early and late appointments as well as appointments on Saturdays. X-rays appointments could be offered as early as the day of referral. For other procedures, depending on the preparation and speciality, an appointment would be offered within the next two working days.
- The reception area in the main building was small. Some patients had to wait in the corridor outside the radiology department at busy times. Conversations at the reception desks could be overheard from the seats in the waiting area. However, there was a sign at the reception desk indicating where patients should wait to give more privacy to patients at the desk. Staff told us that if patients asked to discuss matters in private they would take them to a vacant consulting room if it was

possible to do this but that patients' privacy could not always be maintained. To improve the responsiveness of the hospital to patient's needs and as part of the refurbishment the hospital was looking at expanding or re-locating the existing radiology department.
- Where possible, the service provided imaging appointments in conjunction with the patient's outpatient consultant appointment. For example, the service had created a one-stop shop for urology which meant that patients attending for a review had their X-ray and consultant appointment at the same time which prevented the need for separate appointments.
- The hospital had confirmed that limited car parking facilities impacted on the needs of patients during times of increased activity. Patients spoken with confirmed that parking at the hospital could, on times, be very difficult.
- **See information under this sub-heading in the surgery report section.**

**Meeting people's individual needs**

- **The service took account of patients' individual needs.**
- The waiting rooms had changing areas for the diagnostic services which provided patients with privacy. Patients were seen one at a time, which prevented waiting for appointments in gowns and promoted dignity.
- The service provided, when required, a translation services, hearing assistance, sign language interpreters or other assistance to ensure the individual needs of the patient were considered.
- Patients told us that they were given detailed explanations about their admission and treatment as well as written information. Staff confirmed that written information could be obtained in other languages if required.
- Patients were sent information about any procedure they were having prior to their visit. We saw evidence of ultrasound guided biopsy leaflets and guidance for liquids to be taken prior to their appointment time. However, unless requested, the information seen was not available in other languages where English was not the patient's first language unless requested. Information regarding common children's procedures was available for parents, however, we did not see any information leaflets specifically designed for children.
- Staff confirmed that they were usually unaware if the patient attending the service had mental health needs or other additional needs such as a learning disability or dementia. Staff explained that should a patient become anxious or restless during a procedure they would use distraction and de-escalation techniques to calm patients.
- The main waiting area for MRI, CT and Dexa scanning had reading material and a television to occupy patients whilst they waited for their appointment. There was a clock so patients could keep track of time.
- Although the waiting areas were small, they were large enough to accommodate wheelchairs. We were told that when patients required a wheelchair or assistance to mobilise, staff would assist them into the imaging areas.
- There were patient toilets located within the departments. These were suitable for the use of patients who had reduced mobility and required mobility aids or wheelchairs.
- All children under the age of 16 years received direct care from a registered children's nurse. In the imaging service they were available to chaperone and support the child and their parent/carer. The registered children's nurse also ensured that parent and children and young people information was readily available to inform the parent / carer and children on what to expect.

**Access and flow**

- **Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.**
- Access to the imaging department was through the hospital's main entrance, which had a ramped access. All diagnostic imaging services were delivered over two floors with lift access to individual waiting areas.
- Patients attending the department attended the main reception areas where they were would be either directed to the CT or MRI area or remain in the main X-ray area. A member of the diagnostic team called the patient for their investigation.
- X-rays and ultrasound reporting was completed by the specialist radiologist. Images for ultrasound scans and mammography at one stop clinics were reported at the time of the investigation. All other images were reported on by the specialist radiographer within one week of the image being taken.

Good

# Diagnostic imaging

- The rates of patients who did not attend (DNA), cancellations and abandoned examinations were reviewed and monitored. There were 38 DNAs from October to December 2018. Most DNAs referred to the DEXA service (27) followed by six MRI scans, four CT scans and one each for the ultrasound and fluoroscopy screening. Senior staff confirmed they monitored the number of DNA's.
- There had been nine services cancelled from January to November 2018. Two referred to the MRI, CT and fluoroscopy service and three for the mammography service. Seven of the cancellations referred to equipment failure and two for workflow issues.
- There were no waiting lists for the imaging service as all scans were offered in line with turnaround times. The hospital informed us that turnaround times for private patients were within 48 hours and NHS cases within seven working days.
- Report turnaround times were recorded and if these were below the Ramsay benchmark, there was a written action plan in place with completion dates. Report turnaround times were recorded monthly and taken from the RIS report. Report turnaround times, and action plans (if applicable) were included in the radiology manager's monthly report to the senior management team. The October 2018 NatSSIP audit showed the service had achieved 100%.
- Referral to treatment time is the term used to describe the period between when a referral for treatment is made and the date of the initial consultation or treatment. The diagnostic imaging test waiting times for patients waiting six weeks or more from referral to a diagnostic test form April 2017 to July 2018 was 0%.
- For x-rays, appointments could be offered as early as the day of referral. For other procedures, depending on the preparation and speciality, an appointment would normally be offered within three to five days and reported back to the referring clinician as soon as possible.

**Learning from complaints and concerns**

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- Complaints had been identified as an area of improvement on the quality improvement action plan for 2018/19. This included improving systems in place to provide feedback to all staff related to patient incidents, trends and any learning. Radiographers were aware of the policy for the management of complaints which were accessible on the hospital's intranet.
- Lessons learned from complaints were discussed in departmental meetings and offered staff the opportunity to reflect on the complaint and collectively discuss where improvements could be made.
- Patients who we spoke with told us they did not have any reason to complain during their appointment and said they would feel confident in raising a concern or complaint if necessary. Radiographers said that if a patient raised a concern or wanted to make a complaint they would try to resolve it locally to prevent escalation. Where this was not possible the complaint was referred to the head of department or manager. All complaints resolved locally were recorded in a book and would be escalated further as required. We saw complaints were an agenda item on team meetings.
- A total of 83 complaints had been received at Rivers Hospital from December 2017 to November 2018. There had been four complaints against the radiology service from January to June 2018. There was no identified theme but two related to poor communication and customer care, another for incorrect recording and one for lack of information. We saw the action taken and lessons learnt which included for example; informing patients of the risks if they had breast implants. Radiographers confirmed they were aware of the processes which meant there were systems in place for the cascading of shared learning across the service.
- **See information under this sub-heading in the surgery report section.**

## Are diagnostic imaging services well-led?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

**Leadership**

- **The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.**
- There was clear leadership within the team. The head of department worked clinically in addition to completing management tasks and duties. Radiographers spoke positively about the leadership of the team.
- The manager ensured the diagnostic service understood the IR(ME)R regulations to follow best practice.
- Staff said the executive director and head of clinical services were well respected, visible and always available and supportive when required.
- Imaging staff said they enjoyed working in the department and felt supported by their departmental manager who was accessible and had an open-door policy. The departmental manager spoke with pride about the work and care their staff delivered daily. Many staff working in the imaging service had worked in the organisation for many years. They told us they had stayed in the organisation for a long time because they enjoyed working together as a team.
- **See information under this sub-heading in the surgery report section.**

**Vision and strategy**

- **The hospital had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed.**
- The hospital had a business plan in partnership with Ramsay Healthcare to develop and operate a new radiotherapy centre in 2019.
- The hospital had a vision statement which was to provide an outstanding service to patients and key stakeholders that was commercially sustainable, focused on future growth and delivered by a team who were proud to work at Rivers Hospital.
- The hospital had a strategy whose values aimed to put "people at the HEART of all we do." The hospital had incorporated the six clinical core values (6Cs) which were: commitment, courage, communication, care, compassion and competence.
- Imaging staff were aware that there was a vision and strategy, although did not refer to it directly. Staff referred to changes within the service which were aligned to the vision and strategy. For example, the reconfiguration and expansion of the services were aligned to the five-year strategy.
- **See information under this sub-heading in the surgery report section.**

**Culture**

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Imaging staff spoken with reported a good culture. Staff felt supported by their colleagues, manager and head of clinical services. They told us they were proud to work within the hospital. Staff said their line manager looked after them well. We observed positive and supportive interactions between staff and the manager.
- Imaging staff we met with were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.
- Imaging staff said they felt valued and supported to deliver care to the best of their ability. They confirmed opportunities to develop their skills and competencies was encouraged by senior staff.
- Openness and honesty was encouraged at all levels and staff said they felt able to discuss and escalate concerns without fear of retribution. When incidents had caused harm the duty of candour was applied in accordance with the regulation.
- Imaging staff were enthusiastic about their jobs and the team in which they worked. Staff told us that they "loved working at the hospital." Quotes from staff included, "the team work well together" and "everyone is friendly." Staff also confirmed they enjoyed working with their patients and we observed good interaction during the inspection.
- Team meetings were consistent every month. We saw staff signed to say they had read the minutes which were informative and provided guidance to staff on a range of topics which included; training, incidents and compliments.
- The hospital had launched the "speaking up for safety" (SUFS) programme in July 2018 as part of a Ramsay wide campaign. The aim of the programme was to encourage and empower staff to challenge anyone, including senior colleagues, who may be putting

patients at risk with their behaviour. The programme included assertiveness training and this was being rolled out to all staff. Staff spoken with were very positive about the programme and we saw SUFS champions identified through the wearing of badges.

**Governance**

- **The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- There were structures and processes of accountability in place to support the delivery of good quality services. The service reported directly to the senior leadership team with clear lines of escalation in place.
- The manager attended the local clinical governance committee and heads of department meetings. Minutes seen showed that a standardised format was used which looked at incidents and audits undertaken and their outcomes. Minutes were descriptive and were circulated to the wider team for information. There was a list of attendance and an action log to monitor progress against identified actions. Feedback from these meetings was provided to staff during team meetings.
- Radiographers had access to the radiation protection advisor (RPA) service and confirmed they acted upon the annual report with any identified recommendations. We saw the 2017/18 RPA report with no issues or concerns identified.
- Staff attended the radiation protection and medical exposure committee meetings. We saw the meeting minutes from October 2017 to November 2018. The minutes had a set agenda which included: a review of previous actions and a summary of ongoing and new actions, a governance report which reviewed incidents and lessons learnt and the review of policies. The service manager confirmed they received relevant information from their line manager. Radiographers spoken with confirmed senior managers provided them with information relevant to their role and the service during staff meetings. Staff told us that meeting minutes were also shared across all Ramsay hospitals.
- **See information under this sub-heading in the surgery report section.**

**Managing risks, issues and performance**

- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- The imaging service maintained a local risk register. Risks identified were recorded on a standardised template which scored risks as low, medium or high risk. We saw that the risk register was reviewed regularly and any actions taken to mitigate risks recorded.
- We spoke to senior staff about risks within their service and confirmed the risk register was discussed as part of the service performance review meeting. Imaging staff described their understanding of what constituted as a risk.
- The service manager described the systems and processes which supported the monitoring of performance and issues. They told us they had access to an online system to monitor for example; training compliance and equipment maintenance. We saw folders within the staff room to support staff's knowledge of performance within the imaging service.
- Any performance issues or concerns were escalated through monthly departmental review meetings held between the heads of department, clinical lead, hospital director and finance director. Most of the audits seen had an identified action plan to improve performance.
- A proportion of Rivers Hospital income from April 2017 to March 2018 was conditional on achieving quality improvement and innovation goals, through the commissioning for quality and innovation (CQUIN) payment framework. The hospital participated in two CQUINs which were:
  - Staff health and well-being with the aim of improving staff morale and motivation through a healthier and happier workforce while improving the quality of patient care delivered.
  - Sign up to safety campaign to reduce avoidable harm to patients by 50% over three years.
- The Ramsay CQUIN for 2017/18 identified that the hospital had achieved 75% of its CQUIN by quarter four (January to March 2018) with the aim of meeting 100% for 2018/19. During the inspection staff confirmed that health and well-being was discussed during their appraisal and that morale had improved across the hospital. Staff were aware of the sign up to safety campaign and felt it was a positive way forward.
- **See information under this sub-heading in the surgery report section.**

Good

# Diagnostic imaging

**Managing information**

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Staff could access patient electronic records appropriate to the needs of the investigation being completed. Computers were password protected and locked when not in use. We saw that computers were not accessible to patients.
- The imaging service had access to the picture archiving and communication system (PACS) which allowed the acquiring, storage and transmission of radiological films. This meant that films installed onto the PACS system were filed, managed appropriately and could be accessible day and night for viewing.
- The imaging service used the radiology information system (RIS). RIS is an electronic management system for the management of medical imagery and associated data. The RIS system was used to track patient scheduling and performance tracking. The RIS system was used in conjunction with the PACS system.
- **See information under this sub-heading in the Surgery report section.**

**Engagement**

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- The feedback from the May 2018 staff survey resulted in three staff forums being held in August 2018 with 80 staff attendees across the hospital which included contracted and bank employees. The forums explored the areas for improvement and had created an action plan on the themed areas of concern which included; staff training, communication, equipment, and work-life balance. Staff spoken with said they were aware of the forums but had not attended any.
- The staff engagement group worked with the senior management team and hospital staff by holding regular forums to ensure staff were kept informed and had the opportunity to ask questions. We saw information was passed on to imaging staff by the manager through regular team meetings.
- The hospital gathered patients' views and experiences to shape and improve the services and culture. The business plan identified an action to improve the response rate to 40% by year end (April 2019). However, we did not see any processes in place within the imaging service to collect feedback from patients.
- Staff members had been allocated an individual health and well-being objective which was discussed as part of their appraisal. For example, staff had access to a free online health support which offered advice on nutritional health checks, fitness advice, personal coaching and medical factsheets.
- **For detailed findings on engagement please see the Well-led section of the surgery report.**

**Learning, continuous improvement and innovation**

- **The service was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.**
- The inspection of June and July2016 identified areas of concern. However, during this inspection we found most concerns had been addressed and we saw the following improvements:
  - Controls in place to ensure all equipment was cleaned regularly.
  - Medicine keys were stored appropriately in key cupboards.
  - Policies and guidelines were in date.
  - All staff within the imaging service had received an appraisal.
  - Staff were aware of the hospital's vision and values.
- However, the June and July2016 inspection identified varied results regarding the friends and family test. During this inspection, although the imaging service had received feedback from patients we did not see any processes in place to capture patient feedback.
- Imaging staff felt they could approach other experienced staff for advice and support when required and said they had picked up valuable skills and awareness by working with colleagues who had such knowledge and expertise.
- The hospital had implemented the "speaking up for safety" programme to support the culture of safety and ensuring high professional standards were maintained throughout the hospital.
- There was a culture of improvement in the imaging service. For example, the service had implemented a

Good

# Diagnostic imaging

one stop urology service where patients attending could receive their procedure and be seen by the consultant on the same day which prevented numerous visits to the hospital.

- **See information under this sub-heading in the surgery report section.**

# Outstanding practice and areas for improvement

## Outstanding practice

- The hospital was committed to ensuring children and young people were cared for safely and were free from the risk of abuse. Therefore, staff who were caring directly for children were trained to level three safeguarding children. Whilst this is the required standard and is in line with the intercollegiate safeguarding document 2014, the hospital was demonstrating a higher than average safeguarding children's training rates at level three (83 staff) and (183) safeguarding level two.
- Staff completed annual updates rather than bi-annual which were face-to-face and supported by safeguarding competency checklists and were led by the lead paediatric nurse.
- The hospitals commitment to safeguarding children in their care had contributed significantly to the development of a 'child centred' culture across the hospital. This meant children's services were now seen as a distinct service in their own right which was a significant improvement on our previous inspection.

## Areas for improvement

### Action the provider SHOULD take to improve

- To review processes in place for cleaning schedules to be timely completed.
- To monitor that all staff are fully compliant with infection, prevention and control policies and procedures.
- The oncology service should ensure that personal and protective equipment used for administration of cytotoxic medications are appropriately disposed of in line with cytotoxic waste management guidelines.
- To monitor that all policies and procedures in relation to endoscopy services and chemotherapy treatment are up to date and in line with best practice.
- To review intravenous fluids storage for chemotherapy services.
- To monitor that competencies for all staff, including lead nurses, are annually signed off by a competent assessor.
- The endoscopy service should monitor that all staff have had an appraisal yearly.
- The oncology service should consider collecting information and reporting on patient outcomes for oncology.
- The oncology service should consider that nursing staff across the hospital are trained to triage oncology patients out of normal working hours using the United Kingdom Oncology Nursing Society (UKONS) triage tool.
- To monitor that all intravenous fluids are clearly recorded on prescriptions charts and in-patient notes, to enable accurate fluid management, traceability and identification.
- To review processes in place to capture patient feedback when attending the diagnostic imaging service.
- To monitor that consent is obtained in line with guidance, enabling sufficient time between consent and appointments for patients to consider information shared.
- To ensure that information relating to treatments and conditions is available in child friendly format and for those whose first language is not English.
- To consider that there are facilities in all reception areas to enable private checking in processes.
- Staff within diagnostic imaging should ensure that call bells are answered swiftly.