Woodland Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Woodland Hospital is operated by Ramsay Healthcare UK Operations Ltd. The hospital provides surgery, outpatients and diagnostic imaging services. We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 24 and 25 October 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 report.

Services we rate

Our rating of this hospital improved. We rated it as **Good** overall.

- The hospital provided staff with appropriate training to enable them to complete their roles and responsibilities.
- The hospital premises were clean and well maintained. Services managed infection control risks well. When we escalated concerns relating to hand washing, the hospital responded immediately, implementing additional training and audits to improve practice.
- 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.
- 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.

Summary of findings

- 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 the following areas for improvement:

- There were inconsistencies with patient records. Risk assessments were not always completed within surgical services and outpatient notes lacked details of actions taken and were not always signed and dated.
- Locally, some managers did not have oversight of equipment used within their departments/clinical areas.
- Outpatient services did not routinely monitor the effectiveness of care and treatment.
- There were inconsistencies in the documentation of consent for minor operations within outpatients.
- Complaints' files did not always reflect actions taken to resolve concerns raised.
- There was not always effective oversight of some aspects of risk, safety and governance. Risk registers did not always accurately reflect risks identified by staff.
- Staff in outpatients did not always have oversight of performance, and there was no evidence to suggest that performance data was shared with teams.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with one requirement notice. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was well led, safe, effective, caring and responsive.
Outpatients	Good 	We rated this service as good because it was caring, responsive, and well-led, although it requires improvement for being safe. Effective is not rated.
Diagnostic imaging	Good 	We rated this service as good because it was safe, effective, caring and responsive, and well-led.

Summary of findings

Contents

Good

Location name here

Services we looked at:
Surgery, Outpatients and Diagnostic imaging

Summary of this inspection

Background to Woodland Hospital

Woodland Hospital is operated by Ramsay Healthcare UK Operations Ltd. The hospital opened in 1990. It is a private hospital in Kettering, Northamptonshire. The hospital primarily serves the communities of Northamptonshire. It also accepts patient referrals from outside this area.

Woodland Hospital is a purpose-built hospital over three floors. Since opening in 1990, there have been many changes, including major developments in 2013 and 2018. The latest development increased the number of theatres and introduced a purpose-built day case unit, a purpose-built MRI scanning room and an endoscopy unit.

The outpatient department comprises 12 consulting rooms and two minor treatment rooms on the ground level. Adjacent to the main outpatient department is the imaging department which comprises of an x-ray room, ultrasound facility and MRI suite. There is a mobile computerised tomography unit (CT) which visits the site regularly, managed by Ramsay Diagnostic services. In addition to outpatients and imaging services, there is a physiotherapy department, which has a gymnasium and four treatment rooms. These are in a separate building to the main outpatient department and accessed directly from the main carpark.

There is a small pharmacy department providing services for both inpatients and outpatients.

Clinical inpatient areas consist of an inpatient ward which has 20 patient rooms and a two-bedded room for patients requiring additional observation. The day case unit has 12-day case pods, and seven beds.

The theatre department consists of four main theatres with laminar flow, plus an endoscopy unit which holds Joint Advisory Group (JAG) accreditation.

The hospital undertakes a range of surgical procedures and provides outpatient consultations for adults. The hospital does not provide services for children.

At the time of the inspection, a new registered manager had recently been appointed and was registered with the CQC in October 2018.

There were 112 consultants working under practising privileges; and two anaesthetists employed by the hospital. There were 46.7 WTE nursing and midwifery 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.

The hospital is managed by Ramsay Healthcare UK Operations Ltd and is part of a network of over 30 hospitals and day surgery facilities and two neurological rehabilitation homes, across England.

The hospital provides care for private patients whose care and treatment are either paid for by their insurance companies or are self-funding. Some patients who are funded through the NHS referral system can also be treated at Woodland Hospital. NHS patients make up approximately 80% of the hospital activity.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, Justine Eardley, three other CQC inspectors, one assistant inspector and three specialist advisors with expertise in surgery and governance. The inspection team was overseen by Phil Terry, Inspection Manager, and Bernadette Hanney, Head of Hospital Inspection.

Summary of this inspection

Information about Woodland Hospital

Woodland Hospital was a purpose-built hospital established 27 years ago. The hospital ward had 23 beds which included two high observational beds, four main theatres with laminar flow, a purpose-built day case unit which includes 12 pods and seven bedrooms. Adjacent to the day case unit was an endoscopy unit with a six-bedded recovery bay.

The hospital offered a full range of specialties with orthopaedics representing the largest proportion.

There had been 2,427 patient visits to theatre from April to June 2018, 385 inpatient attendances, 2,091-day case attendances and 1,919 bed days for the same period. The number of bed days refers to the sum of inpatient beds occupied overnight during this period.

For the year 2017/18 there was a total of 10,100 patients admitted to the hospital of which approximately 78% were NHS patients.

The hospital is registered to provide the following regulated activities:

- Diagnostic and Screening procedures.
- Family planning.
- Surgical procedures.
- Treatment of Disease, Disorder or injury.

During the inspection, we visited the inpatient ward, day case unit, outpatient departments and imaging department. We spoke with 40 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 16 patients and relatives. During our inspection, we reviewed 35 sets of patient records, 28 care record pathways for minor operations and seven medicine 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 had been inspected four times, and the most recent inspection took place in March 2017 where the hospital was rated as requires improvement overall.

Activity

- In the reporting period August 2017 to July 2018, there were 1,747 inpatient cases, 8,087-day case episodes and 55,377 outpatient attendances recorded at the hospital. 79% of inpatient and day case patients were NHS funded and 74% of outpatient cases were NHS funded.
- 79% of all NHS-funded patients and 21% of all other funded patients stayed overnight at the hospital during the same reporting period.

The accountable officer for controlled drugs (CDs) was the head of clinical services (matron).

Track record on safety August 2017 and July 2018

-No never events.

-Clinical incidents 1,196 no harm, 48 low harm, 31 moderate harm, no severe harm, no deaths.

-12 serious injuries.

-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 (c.difficle).

-No incidences of hospital acquired E-Coli.

-51 complaints.

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAGS) accreditation

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal.
- Interpreting services.
- Grounds Maintenance.
- Laser protection service.
- Laundry.
- Maintenance of medical equipment.
- Theatre sterilisation services.
- Histology services.
- Computerised tomography scanning (CT).
- RMO provision.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Requires improvement	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

We do not rate effective for outpatients and diagnostic imaging.

Good

Surgery

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

Are surgery services safe?

Good

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

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

Mandatory training

- **The service provided mandatory training in key skills to all staff.**
- The hospital had implemented a new learning management system to record mandatory training and allow staff to complete their training on-line. Staff confirmed they were aware of the new system but not all staff had the appropriate passcode to access the system and commence their on-line training. Senior staff said they were aware of the issues and this was being addressed.
- The head of clinical services (matron) received a weekly training compliance report, which was shared with the heads of department. Mandatory training compliance was also discussed at various meetings, including hospital governance and departmental meetings. The hospital had replaced the previous corporate e-learning system in July 2018, and at the time issued staff with relevant log in details. However, we found that some managers did not have knowledge of their whole team's compliance to mandatory training and were unable to provide us with details. For example, they were unable to tell us about local training compliance rates for the wards generally, or for individual categories like manual handling or basic life support (BLS). Local managers confirmed they received an email when an individual's mandatory training was due or had expired which they passed onto staff.
- Mandatory training at the hospital was delivered through both online learning and face to face training. All completed training was RAG (red, amber and green) rated. We saw training schedules on display within the staff rooms for up and coming training. Staff confirmed they had a training passport which they were responsible for. The passport identified all their training requirements. The service displayed their training availability in the staff newsletter for October 2018. This showed that there were regular training sessions provided for clinical and non-clinical staff.
- We saw both the face to face and e-learning training figures provided by the hospital. We saw the face to face compliance details for eight training modules for October 2018. This was RAG (red, amber, green) rated. Data showed that:
  - Basic life support training had been completed by 91% non-clinical staff, 81% physiotherapy staff, 68% healthcare assistants, 100% pharmacy staff and 90% radiology staff.
  - Manual handling training had been completed by 89% non-clinical staff, 90% nurses, 93% physiotherapy staff, 87% healthcare assistants, 100% pharmacy staff and 100% radiology staff.
  - Medicines management training had been completed by 91% nurses, 100% pharmacy staff and 100% radiology staff.
- The hospital provided us with the overall e-learning training figures for modules which included health and safety, good communication and person-centred care,

information on dementia and emergency management and fire safety. The data showed that all staff had completed their training with the exception of information security (76%) and sharps and blood borne viruses (81%).

- The Association of Anaesthetists of Great Britain and Ireland recommend that all specialist staff within theatre recovery areas have appropriate training in advanced life support (ALS). Training records showed that within theatres, eleven nurses were trained to advanced life support (ALS)
- The company providing the services of the registered medical officer (RMO) were responsible for ensuring they had the appropriate mandatory training, which included ALS. The hospital reviewed the RMO's appropriate training certificates which were signed off by the head of clinical services.
- The resuscitation lead had established an annual audit which covered areas such as education and training, equipment and the review of policies. The October 2018 audit showed 100% compliance with ILS training, for staff who were part of the emergency team. All registered practitioners who had completed their ILS training also covered sepsis as part of their mandatory course content. Local data and hospital wide data did not match.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had completed e-learning safeguarding adult and children's training and had achieved between 91% and 100%, although face to face training was below the hospital target.
- Hospital data showed that 99% of staff had completed Safeguarding Adults Level 1 training and 96% of staff had completed Safeguarding Adults level 2 training. Staff had also completed Safeguarding Children level 1 (97%), Level 2 (91% and level 3 (100%). Training was broken into sessions on different aspects of safeguarding, which included assessment. Deprivation of Liberty Safeguards and Prevent.
- The hospital launched face to face safeguarding training which is additional training to that required as part of Ramsay UK mandatory training requirements, this was supported by the clinical commissioning group safeguarding lead and is in line with best practice. Training compliance for October 2018 was reported as:
  - Registered Nurses and ODPS – 61%.
  - Healthcare Assistants – 73%.
  - Non- clinical staff – 86%.
  - Physiotherapists – 88%.
- Safeguarding adults and children policies were in-date and were accessible to staff through the hospital's intranet. They included guidance on how to manage suspected abuse and radicalisation, and details of who to contact for further support and guidance. The hospital received safeguarding support from the local clinical commissioning group (CCG) safeguarding team.
- 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 manager confirmed they had level 3 safeguarding training and was looking at creating additional learning session for staff within the surgical service.
- 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.
- 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 surgical service showed that most staff had completed their training.
- Staff spoken with had 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.

Good

Surgery

Cleanliness, infection control and hygiene

- **The service controlled most infection risk well. Staff kept themselves, equipment and the premises clean**. Control measures were in place to prevent the spread of infection. However, not all staff complied with the infection prevention and control policy.
- 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).
- The hospital had an infection prevention control lead who offered specialist advice and support on infection prevention control issues.
- Infection control meetings were completed monthly with attendance by staff from all departments. Minutes showed that there was a set agenda which focused on performance against audit results, areas of learning from incidents or complaints and cleaning schedules.
- There was evidence of discussions held and an associated action plan, which staff reviewed at each meeting. We saw that actions were completed in line with the timescales set.
- The hospital held an infection prevention and control focus week in May 2018. Key topics included; hand hygiene, cleaning schedules, aseptic non- touch technique (ANTT) and the correct use of documentation. ANTT is a framework that defines the infection prevention and control methods and precautions necessary during invasive clinical procedures to prevent the transfer of microorganisms. The infection control and prevention audit for October 2018 showed the service was 100% compliant for all procedures carried out using ANTT. This included the re-dressing of wounds and the insertion of urinary catheters.
- Senior staff confirmed that Woodland hospital had recognised and identified concerns with infection prevention and control processes (IPC). This had been addressed through the appointment of an IPC lead and the introduction of 13 champions from all departments and at different levels. A champion away day was held in May 2018. Areas covered included; hand hygiene, surgical site surveillance and how to challenge staff regarding compliance.
- Staff had access to appropriate personal protective equipment (PPE) such as disposable aprons and gloves. We saw staff using masks and eye protection in the endoscopy unit. Staff confirmed they had access to all relevant PPE equipment. Handwashing facilities and hand gel were widely available and easily accessible. All hand wash dispensers that we checked were full and in working order.
- Monthly infection control audits included adherence to hand hygiene protocols. The monthly hand hygiene observational audit for September 2018 showed an overall compliance rate of 70%. The audit contained a summary of the findings which found that substantive staff were 100% compliant while agency staff and anaesthetists were non-compliant. The action was to display hand hygiene posters in all clinical areas. During the inspection we observed hand washing techniques on display across the surgical service.
- While on Ward 2, we observed nursing staff moving between patients and not adhering to infection and hand hygiene practices. This was observed during ward handover and when staff undertook personal care observations. In theatre four recovery area, we observed an anaesthetist inserting a cannula without wearing of gloves. These were brought to the attention of senior management. Following our inspection, the hospital provided us with details of actions taken to address hand hygiene concerns. This included the commencement of daily hand hygiene audits, increased training, infection control champions event and an increased focus on infection prevention and control in inpatient areas.
- All staff seen adhered to the arms bare below the elbow policy with the exception of one consultant on Ward 2. The consultant had on a long-sleeved jacket and watch. Four staff spoken with confirmed that most consultants did not comply with being arms bare below the elbow when visiting the ward prior to surgery.
- The March 2016 inspection report identified a lack of compliance by some theatre staff regarding the correct use of theatre attire. During this inspection, we found the hospital had addressed our findings and we observed all staff using the correct theatre attire. This meant the hospital was compliant with the Standards and Recommendations for Safe Perioperative Practice (2011).
- The wards, operating theatre areas and endoscopy suite were visibly clean and tidy. There was an allocated

housekeeper who was responsible for maintaining the daily cleaning tasks, including deep cleans where required. The hospital had deep clean schedules for the theatre suites. These were undertaken by an external company and we saw the relevant certificates. Clinical deep cleans of the operating theatre department were undertaken by an external company and certificates were provided on completion. We saw cleaning schedules in place and housekeeping staff had signed throughout the day to indicate when the area had been cleaned. We found no issues or concerns during the inspection.

- The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) report for 2014 incorporated cleanliness and infection control. We saw the endoscopy unit had achieved 100% compliance.
- The Department of Health (DH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. We saw that the processes adapted at Woodland Hospital were in line with DH recommendations which meant there was a clear system in place regarding the tagging and numbering of endoscopes and their traceability.
- Staff working in endoscopy described the precautions taken when seeing patients with communicable diseases, this included arranging the theatre list to see the patient at the end of the list when possible and followed infection control procedures. Staff also told us that they would liaise with the infection control lead for advice where applicable.
- 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.
- Data provided showed there were no reported cases of MRSA, C. Difficile, Methicillin-susceptible Staphylococcus Aureus (MSSA), (a type of bacteria (germ) which lives harmlessly on the skin) or E. Coli (a type of bacteria that normally lives in the intestines of people) from July 2017 to June 2018. Staff informed us that all identified infections were reported using the hospital's electronic incident report and management system.
- An external company ensured the safe delivery of portable (drinkable) and non-portable water supplies by overseeing the testing schedules of water systems and outlets. We saw the water sampling results for May 2018. These showed there were no issues or concerns, such as the non-detection of legionella (a bacterium that caused a pneumonia-type illness) and pseudomonas (a common bacterium that can infect the lungs).
- The hospital had a screening and immunisation programme which was in accordance with national guidance, specifically "immunisation against infectious diseases; including pre-employment screening and ongoing health screening".
- Surgical site infections for replacement hips or knees, were reported in line with national guidance. For the period April 2017 to June 2018, there had been four primary hip arthroplasty surgical site infections reported. 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.**
- The hospital had a continuous refurbishment programme which had improved the services offered. For example, we saw the installation of a new nurse call bell system which was checked daily to ensure it was working appropriately.
- The March 2016 inspection found concerns with the storage, use and cleaning of equipment. The environmental audit for July to September 2018 which was RAG (red, amber, green) rated, achieved an overall rating of 81%. The audit was divided into different standards which included; general environment, clinical equipment and practices and hand washing facilities. For example, we saw the overall figure of 70% against the general environment standard; "good standards of general hygiene are maintained to ensure the health and safety of patients and staff." Within the surgical service the theatres and recovery scored 18%, endoscopy 85% and the ward 69%. Areas which were rated red included;
  - All areas are visibly clean and free from extraneous items.
  - There was documented evidence that furniture and all horizontal surfaces are cleaned according to cleaning schedules.

- We did not see an action plan regarding the environmental audit but during this inspection, we found no issues or concerns and saw that all areas were visibly clean and there were documented cleaning schedules on display.
- The maintenance of equipment was completed by Ramsay Healthcare engineers and manufacturers of specialised equipment. The hospital had guidance which defined which equipment would need to be serviced and repaired in-house or off site.
- There was sufficient equipment to maintain safe and effective care such as blood pressure and temperature monitors, commodes and bedpans. 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.
- Most equipment seen had been electronically tested. However, we did see a urine analyser on Ward 2 which was due to be tested in June 2018. This was brought to the attention of the ward manager who informed us they would remove the equipment from use and arrange for the analyser to be checked.
- The heating equipment in theatres was maintained with no issues or concerns identified.
- Most of the patient's rooms had their carpeting removed to improve cleanliness, infection control and hygiene. Cleaning schedules were in place to ensure those rooms which had existing carpet were appropriately cleaned.
- 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).
- Not all rooms had piped oxygen or suction. We were informed this was to be included in an approved refurbishment plan which was on-going. To address this, supplies of portable oxygen cylinders were in place on the ward. We found these to have been checked and in good working order. The hospital had a risk assessment to manage the risk and confirmed there had been no identified incidents.
- All four theatres had a laminar flow ventilation system which was regularly checked while the endoscopy suite had a non-laminar flow system. Laminar flow minimises contamination to reduce surgical site infections.
- 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.
- There were processes and procedures in place for tracking equipment used for each patient's endoscopic investigation, including sterile equipment used for biopsies and details of staff members who operated and decontaminated the equipment. Following use, equipment was decontaminated and stored in appropriate storage cabinets. The endoscopy staff monitored the decontamination system daily and weekly, ensuring that there was sufficient clean equipment to meet the demands of the service.
- 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.
- Resuscitation "crash" trolleys containing medicines and equipment required in an emergency, were accessible. The March 2016 inspection found that checklists had not been completed on the wards. During this inspection we found the trolleys were safely secured with tamper proof seals and daily checks had been maintained during business hours which ensured medicines were available and ready for use.
- The Patient Led Assessment of the Care Environment (PLACE) for 2017 showed the hospital had scored 96% for condition, appearance, and maintenance, which was higher than the England average of 94%.

Assessing and responding to patient risk

- **Staff assessed risks to patients so they were supported to stay safe. However, we found inconsistencies with the completion of observation charts to maintain patient safety.**
- The surgical service had an admission policy which set out guidelines for the safe admission of patients. Every patient would attend a face to face nurse led pre-assessment and if required a pre-admission assessment by a consultant anaesthetist. During the assessment all necessary tests were undertaken, for

example, MRSA screening and blood tests. This was in line with NICE guidance CG3: Preoperative assessments and NG45: Routine tests for elective surgery (April 2016) and guidance from the Modernisation Agency.

- The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk. For example, ASA1 was low risk and used for healthy patients, ASA3 was a higher risk and used for patients with severe systemic disease. Grades were recorded during pre-assessment by nurses and on admission for surgery by anaesthetists. High risk patients are more likely to have complications following surgery and may require high dependency nursing following their procedure. Patients identified as being at higher risk or who had complications diagnosed following their test results were referred to the consultant for further review. Most patients operated on in the service were classed as ASA1 or ASA2 risk. ASA3 patients were accepted if the anaesthetist was happy with the risk following their assessment. The service had an exclusion criterion, which included unstable ASA3 patients, and all patients graded as ASA4 or higher.
- The hospital had a two-bed unit to care for patients who required level one nursing care and observation. Patients were pre-booked to ensure the appropriate staff were available to monitor the patient.
- Staff attended a safety huddle in theatres in the morning to ensure all patient needs and risks were identified. Heads of department attended a daily communication meeting each day to review and assess the risks to patients attending the hospital. We observed the theatre team safety huddles and saw that staff checked that all ordered equipment had been received and that staffing arrangements and allocated responsibilities were understood. Staff were made aware of any changes to operating lists. We observed a meeting in progress and noted all patients on the operating list were discussed.
- 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 September 2018 results, based on 30 records was RAG (red, amber, green) rated and showed an overall score of 80% (amber). Scores ranged from 0% to 100%. For example; the service scored 0% for nutritional assessments using the malnutrition universal screening tool (MUST) for patients calculated with a BMI below 20 or above 30 to 100% for pre-operative tests such as chest x-rays, blood and urine analysis.
- The patient journey action plan for September 2018 had identified 12 questions for review. We saw that eight of the questions had deteriorated and four had improved. All actions were on-going with a review date of October to December 2018. The action plan identified a re-audit for November 2018. Areas which had deteriorated included:
  - VTE prophylaxis had not been reviewed by the surgeon post-surgery (a deterioration of 45% from previous score of 38%).
  - A legible GP discharge summary/letter was completed, checked and signed by a doctor (a deterioration of 23% from previous score of 100%).
- Risk assessment 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. During the inspection we looked at 24 records and found five incomplete VTE assessments. We fed our findings back to the senior leadership team during our inspection. The patient journey audit for September 2018 showed a compliance rate of 92% based on 13 records.
- Service data showed that compliance with VTE risk assessment completion was over 97% from July 2017 to June 2018. There were also two reported incidents of hospital acquired VTEs which had occurred from July to September 2017 and October to December 2018. Data showed that these incidents were two cases of pulmonary embolism (PE), and learning identified was shared with the wider team.
- During the inspection we found inconsistencies in the completion of height, weight and BMI scores. During the inspection we looked at 24 records and found five did not have identified height, weight or BMI scores and another did not have a risk assessment for a BMI over 40. There was no evidence they had been offered advice on how to access help and support for weight loss. Our findings were comparable with the patient journey audit for September 2018 which showed a compliance rate of 59% for the recording of height, weight and BMI based on 30 records.
- The hospital informed us that 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 24 records seen.

- The National Early Warning Score 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). The patient journey audit for September 2018, showed the hospital had achieved 100% based on six records. During our inspection, we looked at 24 patient NEWS 2 scores and saw that they had been calculated accurately. However, seven of the NEWS 2 charts seen did not include the recording date and two did not have the admission date, which made it difficult to assess what day the recordings had been made. This was brought to the attention of the ward managers during the inspection.
- Information was available to help staff identify patients who may become septic. The hospital participated in a world sepsis day in September 2018. This included awareness and drop-in sessions facilitated by the critical care lead. Sepsis is a serious complication of an infection.
- The service followed guidance from the Sepsis Six. This 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.
- There were arrangements in place with a local acute trust to provide 24-hour emergency support if patients deteriorated and required high dependency nursing or urgent diagnostics. A service level agreement (SLA) was in place with the ambulance service for the safe transfer of patients to the local NHS trust. There had been six unplanned patient transfers to a local NHS trust from April to June 2018.
- 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.
- Patients were transferred from theatre to the recovery area. We observed the anaesthetist, surgeon and scrub nurse verbally handed over the treatment carried out and discussed the aftercare including any medication requirements, immediate post-operative mobilisation and positioning of the patient.
- Items used in theatres, known as 'accountable items' were checked by two members of the theatre team using an instrument check list. Accountable items are reusable or disposable items which by nature are at risk of being retained in a patient, such as swabs and needles. These were documented on a count board in theatre and in the patient records. This was checked pre- and post-operatively and staff signed to confirm this had been undertaken.
- 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 in the procedures we observed. Before surgery, staff gathered for a team brief to go through the WHO checklist and ensured all safety elements of each procedure was considered before starting. This included checking patient identity, the operating site and that all staff involved were clear in their roles and responsibilities.
- The completion and compliance of the WHO checklist was audited by the service. Results from April to July 2018, showed 100% compliance with the completion of the paper forms. The new theatre manager confirmed they had only recently implemented the observational WHO checklist audit which we saw had been included in the theatre action plan.
- We did not see any evidence of patients being assessed as being at risk of developing a pressure sore or at risk of a fall while at the hospital. Staff informed us they had not had any patients that required an assessment for pressure sores or were at risk of a fall. However, there

had been a total of 15 falls during this reporting period (August 2017 to July 2018). The hospital confirmed there had been zero pressure ulcers identified within the hospital. We noted that pressure ulcers and patient falls were not included in the patient journey audit.

- National Safety Standards for Invasive Procedures (NatSSIPs) were available in the theatre department. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). A dedicated NatSSIP checklist was in place for invasive procedures, such as catheters and arterial line insertion and removal. Staff we spoke with in the theatre department were aware of national and local safety standards.
- 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. Practising privileges are granted to doctors who treat patients on behalf of an organisation, without being directly employed by that organisation. Most doctors working in this service were also employed by local NHS hospitals. Surgeons had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover if they were not available, for example when they were on holiday.
- 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. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care.
- The recovery area had six bays which were open from 8am to 9pm or later, dependent on the individual patient's recovery needs. Piped oxygen and suction was supplied to each bay. The recovery area followed theatre monitoring guidance when assessing and responding to the patient's risk which included end tidal capnography. End tidal capnography is a tool used during anaesthesia for the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases.
- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required. These were routinely tested to ensure they were fit for purpose.
- Patients with known allergies wore a coloured wristband, which acted as an alert to staff providing care and treatment. We saw allergies were documented in patient notes.
- Nursing handover sheets were typed by the ward administrator and each member of staff had their own copy. We saw that information printed on the handover included every patient's full name, date of birth, hospital number and the procedure they were admitted for. Nurses carried their copy in their uniform pocket, and referred to it throughout their shift to ensure essential tasks were completed. Most staff (91%) had completed their information security and general document protection regulation (GDPR) training and confirmed there were secure confidential data/shredding cupboards available. There had been no incidents reported specific to lost or found handover documents.

Nursing and support staffing

- **The service had enough nursing 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 senior team reported a recent investment in staffing over the 12 months preceding the inspection. This included an investment in heads of department and support staff, such as governance and training roles.
- A formal acuity tool was used to assess dependency. The staffing tool was in line with NICE staffing guidance and planned staff skill mix seven days in advance, with continuous review daily. Patient admissions were known in advance and staffing levels were calculated accordingly. Patients that required one to one or one to two nursing, were staffed separately to the ward staffing levels. Theatre staffing was planned and provided in accordance with The Association for Perioperative Practice (AfPP) guidelines. During the inspection, we observed a good skill mix across the surgical service with appropriate levels of nursing staff to meet patient needs.
- Ward and theatre managers incorporated information from patient risk assessments when assessing daily staffing requirements. These determined the ideal levels of observation required. Requests for additional staff were made usually 24 hours in advance to the staff bank to cover the gaps. There were occasions when these

requests remained unfilled and the nurse in charge of the ward said they reviewed the risks and reduced it to its lowest level possible across the service. We found no issues or concerns during the inspection.

- The hospital ensured there were appropriately trained orthopaedic scrub nurses working within the theatre team. The hospital had managed the shortage of orthopaedic scrub nurses by utilising staff from other Ramsay hospitals. They also block booked agency staff, which ensured they were aware of Ramsay protocols and processes to mitigate risk and maintain patient safety.
- The service used safer staffing boards to show staffing ratios in each area. These were updated regularly to reflect changes to staffing levels during the day.
- Bank and agency 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.
- The hospital aimed to use minimal bank and agency staff. We saw the rate of inpatient and theatre bank and agency usage from August 2017 to July 2018.
  - The rate of inpatient bank and agency usage for nurse and midwifery registered staff ranged from 9% in August 2017 to 13% in July 2018. The highest months were March and April 2018 at 17% and 16% respectively.
  - The rate of inpatient bank and agency usage for health care assistants ranged from 16% in August 2017 to 2% in July 2018. There had been no agency usage for the three months May to July 2018.
  - The rate of theatre bank and agency usage for nurse and midwifery registered staff ranged from 9% in August 2017 to 13% in July 2018. The highest months were March and April 2017 at 17% and 16% respectively.
  - The rate of theatre operating department practitioner (ODP) and health care assistants ranged from 16% in August 2017 to 2% in July 2018. There had been no agency usage for the three months May to July 2018.

Inpatient nurses and health care assistants employed by the hospital

- Nursing and midwifery registered staff- 19.1 whole time equivalent (WTE)
- Health care assistants- 4.2 WTE
- Theatre- nursing and midwifery registered staff- 19.4 WTE
- Theatre- ODP registered and health care assistants- 18.6 WTE

(Evidence source: IH PIR template provided by the hospital)

Sickness levels

- From April to June 2018, sickness levels for inpatient and theatre nursing and midwifery registered staff was between 0% and 4.7%. Theatre ODP and health care assistant sickness levels were slightly higher and recorded as 5.8% to 7.9% for the same period. Inpatient health care assistant sickness was between 1.9% and 5.4%, with a peak of 17.8% in May 2018. (Evidence Source: PIR 2 Provided by the hospital)
- Senior staff confirmed they maintained a focus on recruitment and retention activities across the surgical service. Staff confirmed they attended university job fairs to promote the diversity of roles that they could offer. We saw that staffing was included on the local risk register.

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.**
- Patient care was consultant led. There were 112 consultants with practising privileges working at the hospital. 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.
- For consultants to acquire and maintain practising privileges they had to provide evidence they were fit to practice. Evidence required included current registration with the General Medical Council, indemnity and a current disclosure and barring service certificate.
- Consultants were required to produce evidence annually of their professional registration, revalidation,

indemnity insurance, appraisal, mandatory training and continuous professional development before their practicing privileges were renewed. Revalidation formed part of the annual appraisal.

- The hospital practising privileges agreement required all consultants, surgeons and anaesthetists to be available post operatively, within 30 minutes. In addition, the agreement required that all patients were reviewed daily while on the ward and more frequently if necessary according to clinical need, or at the request of the executive director, head of clinical services or registered medical officer (RMO).
- The service RMO was supplied by an agency, who provided medical advice and assistance 24 hours a day, seven days a week on a rotational basis. A standby RMO was also scheduled by the agency in case of sickness or absence. Nursing staff said they only contacted the RMO overnight in an emergency. The senior leadership team had reviewed the RMO curriculum vitae (CV) to ensure that the doctor had adequate and suitable qualifications prior to accepting the person for duty on site.
- 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 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 had a daily handover with nursing staff and discussed each patient. The RMO would contact the consultant, an anaesthetist and the head of clinical services with any concerns and reported having a good working relationship with the hospital pharmacist.
- Should the RMO be disrupted during the evening this was recorded and reviewed and a decision made to contact the RMO's agency for additional cover if this was deemed appropriate.
- The hospital had employed two anaesthetists, while other consultant anaesthetists had practising privileges at the hospital and provided on-call cover when needed.
- There was an on-call system for consultants and a buddy system utilised for absences which including annual leave. This process advised the hospital who was covering when the consultant was unavailable.
- 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.
- Staff we spoke with confirmed that consultants were available and reviewed patients when requested to do so. We saw evidence of this inpatient notes. We saw consultant contact numbers were available for staff. Patients we spoke with said they had seen their consultant at least once post operatively.

Records

- **Staff kept appropriate records of patients' care and treatment. Records were kept in locked cupboards to maintain confidentiality.**
- The hospital used a paper based system for recording patient care and treatment. Patients' medical records were stored securely in locked cupboards.
- We reviewed 24 sets of patient records and found these to be in good order. Medical and nursing records were 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.
- We found fluid balance charts were included in most records. However, we found inconsistencies in the completed calculation of fluid balances in six of the 24 records seen. This was brought to the attention of the ward managers. The patient journey audit for September 2018 showed a compliance rate of 50% which was based on two records.
- The hospital senior leadership team recognised that contemporaneous medical records did not contain all appropriate clinic letters and diagnostic results relating to private patients. It had been agreed that all pre-operative correspondence for private patients was to be provided by consultants in accordance with the general medical council guidelines. This had been discussed at the clinical governance and medical advisory committees and it was agreed that an audit commitment for a peer audit by consultants would be

established to monitor standards and compliance. This continued to be a work in progress and records were in the process of transition to incorporate all the appropriate documentation.

- 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.
- Intentional care rounding was completed by healthcare assistants (HCAs) on the medical wards. Intentional care rounding is a structured process with staff carrying out regular checks with individual patients at set intervals. For example, we observed HCAs visiting patients to check that call bells and drinks were within reach and asked if the patient was comfortable or in any pain. We saw these were documented in the patients' records reviewed.
- 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.

Medicines

- **Medicines were prescribed, given and recorded in line with best practice. Patients received the right medication at the right dose at the right time.**
- The medicines' management policy was due for review in October 2017. Managers told us that the policy was part of the Ramsay Health Care UK group review and this would be done corporately. However, there was no evidence within the policy to show that it had been reviewed and the information contained within the report could be utilised until it had been updated corporately.
- Medicines were supplied by the onsite 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.
- The pharmacy department was open Monday to Friday 9am to 5pm and 9am to 2pm on Saturday. A clinical pharmacist was on-call 24-hours a day, seven days a week to advise and support staff as needed. In addition, the registered medical officer (RMO), heads of department and the head of clinical services (matron) could access stock items from the pharmacy in an emergency. Medicines for patients to take home were stored in a specific cupboard on the ward.
- Staff followed procedures for the safe administration of medicines in line with guidance from the Nursing and Midwifery Council, safe medicines management. Staff had good knowledge of safe medicines management.
- The pharmacist worked in collaboration with the clinical team to provide training and ensure that medicines were managed well. There was a medicines management sub-committee which fed into the local clinical governance committee which enabled any issues to be identified and escalated. The medicine management subcommittee monitored any actions associated with medicines related incidents and audits. This process ensured that there was oversight of all activity related to medicines management.
- The medicine safe and secure audit for September 2018 achieved an overall rating of 98%. The worst area was; "the identifying of patient's own medicines to ensure they were appropriately labelled" which achieved a rate of 70%. We saw the action which said that "patients should be advised on pre-assessment to bring their medicines boxes rather than just strips." However, there was no outcome regarding the action which meant that we were not sure of the processes in place to manage this. During the inspection we saw that patients' own medicines were stored securely. However, there were a variety of patient medicines which were unboxed. This meant that we could not be assured that information had been cascaded to staff and lessons learnt based on the outcome of the audit.
- Medicine was administrated as prescribed on the medication chart. We looked at seven medicine charts and all were correct except for one medicine given which was not dated. This was brought to the attention of the nurse in charge.

- 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 drugs and antibiotics. Controlled drugs (CDs) are medicines such as morphine which are controlled under the misuse of drugs legislation. We saw all CDs were checked daily by two nurses in accordance with guidance. All intravenous fluids were stored appropriately and accessible to relevant staff. The pharmacy team undertook monthly and quarterly audits with any identified issues fed back directly to the wards for learning and improvement.
- We saw the CD audits for June and September 2018, which showed an overall result of 92% and 99% respectively. The summary on the September 2018 identified:
  - Errors in the controlled drugs register had not been correctly amended.
  - Not all drug administration charts had been signed by the person witnessing the administration of the drug.
- The action included:
  - Reiterate to nurses that each drug administration needed to be signed by the person witnessing the administration of the drug.
  - Reiterate to nurses the importance of amending the CD register correctly.
- The September 2018 CD audit action plan did not have a date for completion or the person responsible of applying it. This meant that we could not be assured there were processes in place to oversee the management and control of CDs appropriately. However, during the inspection, we did a check of CDs and did not find any issues or concerns.
- We observed two registered nurses checking a controlled drug administration as per the hospital's protocol. The staff followed correct procedure when checking the drug against the prescription chart and correctly checked the patient's wristband and name both verbally and against the prescription chart. The medicine missed dose audit for June 2018 was 100% compliant.
- Pharmacists visited the ward daily and provided advice in the use of and management of medicines across the wards. Pharmacists were invited to attend ward rounds and conducted medicines reconciliation, and any medicines related activity. Medicine reconciliation is the process of ensuring that the list of medicines a person is taking is correct. We saw the medicine reconciliation audit for September 2018, which showed the hospital had achieved 81%. The areas identified as low were:
  - Have all intentional changes to medicines, including newly started/stopped/altered been documented.
  - Have all unintentional discrepancies identified been documented.
- We noted that the summary and action plan area on the reconciliation audit had not been completed which meant that we could not be assured there were processes in place to manage discrepancies. However, during the inspection we did not find any issues or concerns with medicines.
- The medicine management audit had an overall score of 92%. However, the summary found that:
  - Not all departments were reporting to pharmacy when temperatures were outside the range.
  - A few entries had been missed with temperature recording with no indications as to why.
  - No identified trends from the hospital's incident recording system.
- The action plan identified that a new monitoring system had been put in place which was reviewed by the quality information lead. During this inspection, we saw that staff understood the importance of monitoring the fridge and room temperatures daily. There was guidance tin place on how to manage fridge and clinical room temperatures when they were not within recommended ranges. This included reporting to the pharmacy team. We found no issues or concerns regarding the monitoring of fridge and room temperatures.
- The medicine charts had been reviewed and updated and now contained an area which identified whether the patient had a VTE assessment. The pharmacist and nursing staff confirmed that they preferred the new chart and found it easier to use.
- Medicines and equipment for use in emergencies were ready accessible to staff and were checked regularly.
- The pharmacist had held a medicine management focus week which looked at key aspects of pharmacy activity. They provided external presenters and training sessions for staff.

Incidents

- **Safety incidents were managed in line with best practice. Most staff recognised incidents and reported them appropriately.**
- Most staff recognised incidents and reported them appropriately. However, the RMO told us that they had never reported an incident as they did not have access to the hospital's incident reporting system and verbally reported any concerns to the senior management team. Senior staff confirmed they were looking at processes to enable the RMO to access the incident system. Therefore, we were not assured that all potential incidents and near misses were reported on every occasion.
- The hospital used an electronic incident reporting system and nursing and clinical staff we spoke with knew how to report incidents. Most staff understood their responsibilities to raise concerns and report incidents. The service had several methods to ensure lessons were shared and disseminated the learning from incidents. Examples included:
  - Quarterly quality and patient safety newsletters and medication safety newsletters.
  - Ward safety huddles.
  - Information placed on the "WhatsApp", a system which staff could access from their mobile phones.
- Clinical staff told us they were encouraged to report incidents and most staff said they received feedback from incidents they had reported.
- Serious incidents were investigated with any identified learning communicated to staff. The hospital had 12 serious incidents for the year 2017/2018. We reviewed the results of a root cause analysis from a serious incident which included the recommendations and related action plan. Most of the actions had been completed and those outstanding had been updated.
- We saw that duty of candour was applied where appropriate. For example, one serious incident detailed ongoing discussions between the patient, the corporate team and the local hospital team. Conversations were detailed and included apologies, the actions taken and discussions encouraging the patient to share their experiences with the wider team through learning events and patient forums.
- Hospital data showed that there were 1,196 incidents reported from July 2017 to June 2018. 1,117 (93%) were recorded as no harm, 48 (4%) low harm, 31 (3%) moderate harm. There were no incidents recorded which resulted in severe harm or death.
- From July to September 2018, there had been a total of 148 clinical incidents of which 130 related to theatres and inpatients. For the same period there had been 46 non-clinical incidents of which 31 related to theatres and inpatients. For clinical incidents, the main incidents identified referred to incorrect/incomplete documentation (40) while missing/faulty equipment had 22 incidents. Both clinical and non-clinical incidents regarding the theatre change of list was at 22 and 15 respectively.
- From April 2017 to March 2018, there had been a total of 75 medicine incidents. Key categories identified included: medication and intravenous related (IV) /other (38) and patient management/medication and IV related medication error (20). We saw the actions required for improvement which included:
  - Focus week planned for April 2018.
  - Creation of medicines management sub group committee to monitor pharmacy performance and medication issues which will include, off licensee medication, medication incidents, IV related incidents.
  - Plan a program of education throughout 2018/2019 to reduce incidents through greater education and training.
- During the inspection we saw paperwork relating to the medicine focus week which took place in April 2018 and we saw evidence that a medicines management subcommittee had been created.

Safety Thermometer (or equivalent)

- Woodland Hospital was compliant with the reporting guidelines in relation to the NHS Safety Thermometer. This formed part of the hospitals' engagement with the local clinical commissioning groups nationwide. Areas identified for reporting included:
  - Venous thromboembolism (VTE) (a blood clot in the vein).
  - Falls.
  - Catheter related urinary tract infection.
  - Pressure ulcers by category.
- The surgical service told us they had systems in place to monitor the number of falls, pressure ulcers, catheter related infections and VTE that occurred for inpatients in line with national guidelines. Senior staff confirmed that

where applicable, the patient journey audit captured the monitoring process. However, we saw that the September 2018 patient journey audit did not capture evidence of falls or pressure ulcers.
- We saw that there was VTE screening processes in place and the hospital had carried out audits. Analysis of the 2016/17 data showed there was 99% compliance with VTE screening. During the inspection, we looked at 24 patient records and found that VTE screening had not been completed in five of the records.

Safety Alerts

- **Emergencies were planned for and staff understood their roles if one should happen.**
- National patient safety alerts were circulated through email or a 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.
- The hospital had plans and strategies to respond to emergency situations, to ensure appropriate action was taken should any incidents arise.
- Nursing staff informed us they participated in a weekly fire alarm test. They outlined the procedures taken which included escorting visitors to the appropriate fire exit. Fire training had been included and there were fire marshals available within the surgical services visited to respond to any identified emergency.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- **Care and treatment was provided based on national guidance and evidence of this effectiveness. Managers assessed staff compliance with guidance and identified areas for improvement.**
- 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, the weekly corporate newsletter and the "WhatsApp" mobile telephone link.
- 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 at each meeting. Senior staff explained the processes undertaken to review policies and procedures.
- 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 for 2018/2019 which was divided into three areas;
  - Ramsay Health Care audit which included infection prevention and control.
  - An audit required by the clinical commissioning group (CCG) which included the World Health Organisation (WHO) surgical check list, and
  - National audits such as the National Joint Registry.
- The hospital could benchmark the results from the audits with other hospitals within the Ramsay Health Care group. However, most staff were unaware of the results of their areas and could not tell us about measures the service had undertaken to improve compliance.
- The theatre manager was new in post and confirmed they were currently ensuring the theatre action plan was up to date with all outstanding items being addressed. We saw the theatre action plan was referenced against the Association for Perioperative Practice (2016) Audit Toolkit, NICE (2010) Venous thromboembolism (VTE) (a blood clot): reducing the risk and Ramsay group policies and associated standard operating procedures. The theatre action plan had been divided into three specific areas; operational, records and theatre observational audits. Areas covered included; medicine management,

equipment, infection control and records management to include consent and VTE. We noted that all areas with a score of 80% or below were being re-audited in November 2018. Examples included;

- Pressure areas and skin condition are assessed and monitored before and after surgery and are completed using a recommended tool.
- There was evidence that all theatre staff had completed competencies relevant to their role within six months of appointment and were 100% compliant.
- There was evidence in the medical/anaesthetic record that the anaesthetist had recorded their discussion with the patient about the risks, benefits and alternatives to their anaesthesia and their consent was documented.
- The VTE risk assessment form had been reviewed and fully completed by the surgeon.

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. Dietary adjustments were made for patients for religious, cultural, personal choice or medical reasons when required.**
- 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.
- 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 with nausea or vomiting were prescribed antiemetic medicine (a drug effective against vomiting and nausea). Patients were given antiemetics intravenously in the recovery area if they complained of nausea post operatively.
- We observed lunch being served. The hot food was delivered in a timely manner on warmed plates and there was a variety of food options, including vegetarian, and gluten free if required. This encouraged patients to eat and it ensured their nutritional needs were met. Patients spoken with said that most meals were basic but they understood that the meals met their daily requirements.

Pain relief

- **Patients' pain was managed effectively and they were provided or offered pain relief regularly. However, post-operative pain relief instructions were not always recorded.**
- 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). 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.
- We saw the pain relief audit for September 2018 which was RAG (red, amber and green) rated. The results showed a compliant rate of 70% (amber) with totals ranging from 0% to 100%. An area which was red (0% rated) included; "postoperative pain relief instructions are recorded." The pain relief audit had an area for a summary and action plan which was not completed and therefore, we were not assured there were procedures and processes to manage poor compliance.
- Pharmacy staff told us they 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.
- An on-site pharmacist worked in collaboration with staff and provided teaching sessions to enhance service delivery in relation to pain relief and medicines management.

Patient outcomes

- **The effectiveness of care and treatment was monitored and findings consistently used the findings to improve outcomes.**
- Information about the outcomes of a patient's care and treatment, both physical and mental were routinely collected and monitored. This was done through both local and national audits. Examples included the national joint audit, infection and prevention and controlled drugs audits.
- Endoscopy services were delivered in line with the British Society of Gastroenterology guidance. The endoscopy services had maintained its Joint Advisory Group on Gastro-intestinal Endoscopy (JAG) accreditation. For example, we saw the hospital had achieved 100% in all eight standards in 2014 which included, premises, facilities and organisation of the department and the maintenance of flexible endoscopes and storage. The JAG report (2014) made a couple of recommendations which included the investment of equipment and a review of the nursing establishment if the service was going to expand. The service had created an action plan based on the recommendations and had reviewed the nurse staffing levels and expanded the service to include four registered nurses and two healthcare assistants. There had been investment in new equipment with the installation of a new washer and dryer with the latest stacks (trolleys) and endoscopes (a piece of equipment that allows the doctor to see inside the body).
- The endoscopy unit had adapted the World Health Organisation (WHO) surgical safety checklist. This was used for every patient undergoing a surgical procedure. The WHO checklist was made up of three components;
  - the sign in which included confirmation by the patient of their identity, site of surgery and consent;
  - the time out which included confirmation by the staff team of any identified concerns and before the incision of the skin;
  - the sign out which includes details of the procedure, recorded and that all instruments used have been accounted for before the patient leaves the operating room.
- We saw evidence of the WHO checklist in use during the inspection with no issues identified.
- We saw the latest data release from the Health and Social Care Information Centre (HSCIC) regarding mortality data based on the Summary Hospital-level Mortality Indicator (SHMI). The SHMI is a nationally agreed mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. The data provided by the hospital was below the England average.
- The hospital had contributed to the National Confidentiality Enquiry into Patient Outcome and Death (NCEPOD); Peri-op Management of Surgical Patients with Diabetes. NCEPOD performs investigations to determine if a patient's death was inevitable (unpreventable), and makes recommendations based on the findings of the studies it undertakes. The hospital was awaiting the report which was due to be released in November 2018.
- Woodland Hospital participated in the National Patient Reported Outcomes Measures (PROMS) for hip and knee surgery for NHS patients. The PROMS were reviewed quarterly by the quality team and senior leadership team and reported through the local clinical governance meeting and the audit and clinical effectiveness meetings. The data showed that patient surgery and health gains were within the national average for hip replacement. The data for knee replacement was slightly above the national average.

Patient Reported Outcome Measures (PROMS)

- A proportion of Woodland 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 harms to patients by 50% over three years.
- The quality report 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 morale had much improved across the hospital and were aware of the sign up to safety campaign.
- The hospital participated in the National Joint Registry with 100% compliance reported over the period April to June 2018.
- 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. We saw the results for 2017 which showed that Woodland Hospital achieved scores higher than the England average for cleanliness, condition, appearance and maintenance and privacy and well-being. The hospital scored slightly lower than the England average for ward food and disability.
- There had been six unplanned in-patient transfers to another hospital from April to June 2018, three unplanned readmissions to Woodland hospital within 28 days of discharge and three patients returned to theatre in the same period. The service monitored the number of transfers out of hospital and reported each one as an incident.
- All patients readmitted to the hospital following their procedure were reviewed by the duty doctor and a treatment plan initiated. The statistics regarding readmissions were reviewed on a bi-monthly basis at the medical advisory committee and clinical governance committees.

Competent staff

- **There were measures in place to ensure staff were competent for their roles.** At the time of the inspection, appraisals had not been completed for all staff within the surgical service. The newly appointed theatre manager confirmed they were aware of the shortfall amongst theatre staff and confirmed this was a work in progress. Staff spoken with confirmed they had been appraised alongside their work performance.

Appraisals

- Hospital data showed that appraisals had been completed by 57% of inpatient nursing and midwifery registered staff and 60% of inpatient health care assistants. Theatre staffing appraisals scores were slightly higher with 70% of registered nurses or midwives in theatres and 75% of registered ODP and health care assistants completing the appraisal process.
- The hospital was rolling out the Acute Illness Management (AIM) and NEWS 2 training course as of September 2018. AIM provides registered healthcare professionals with the knowledge necessary to enable them to recognise, assess and manage acutely unwell adult patients. The training figures showed that since initiation 19% (19 of 99 staff) had completed the AIMs training and 24% (31 of 131 staff) had completed the NEWS 2 training. Additional training dates were secured from November 2018 onwards with 12 places per session.
- 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.
- To ensure staff were kept up to date with current legislation they completed a statutory training programme which all staff were required to attend. Attendance was monitored at divisional level. Staff spoken with during the inspection confirmed they had either completed their statutory training or were aware of up and coming training dates.
- There were competencies in place, which were general to the Ramsay Health Care group. These included intravenous drug 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. For example, we saw the equipment competency figures for endoscopy which showed 100% compliance. Areas covered included; gastrointestinal endoscopy and urodynamic (a study that assesses how the bladder and urethra are storing and releasing urine).

- 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.
- The hospital had established a resuscitation lead. They informed us and we saw evidence they had been supported in training staff and in creating emergency scenarios for staff development. Any gaps in knowledge, for example from resuscitation scenarios, were fed back to the relevant managers. Staff spoken with provided us with examples of how they had participated in emergency scenarios and said they found these to be very useful.
- RMOs' had their mandatory training provided and competencies assessed and updated by the external agency provider.
- 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 head of clinical services.
- Procedures were carried out by a team of consultants and anaesthetists who were predominantly employed by other organisations such as the NHS. Their annual appraisals were carried out with their employer. It was the responsibility of the registered manager, with advice from the medical advisory committee (MAC), to ensure consultants were skilled, competent and experienced to perform the procedures they undertook.
- The hospital checked registration with the General Medical Council (GMC) and the relevant specialist register. In addition, in line with the Ramsay Health Care practising privileges policy, the MAC checked that consultants had no criminal record through DBS checks and that they had up to date indemnity insurance. The DBS is a criminal record checks and helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. While indemnity insurance is designed to protect professionals when they are found to be at fault for a specific event. We saw evidence that there was a system in place to check that all information was up to date and this was discussed and reviewed in the MAC meeting minutes.
- Practising privileges for consultants were reviewed every other year. The review included all aspects of a consultant's performance; an assessment of their annual appraisal, volume and scope of practice plus any related complaints or incidents. The MAC advised the hospital about continuation of practising privileges. We saw that the hospital used an electronic system to check when privileges were due to expire.
- 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. Data provided by the hospital showed they had achieved 98% compliance which meant that staff registration requirements were kept up to date so that they could appropriately support new learners.

Multidisciplinary working

- **Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- 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.
- The pharmacy worked well with staff on the surgical wards and provided the following services; medicines reconciliation, an assessment of the patient's own drugs and drug 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.
- We saw the orthopaedic multidisciplinary clinician meeting minutes from July to October 2018. These were

attended by a representative from the physiotherapy and radiology departments. The minutes outlined the patients' discussed and reviewed their investigations, relevant co-morbidities together with any outcomes and actions which included for example, the arrangement of a high dependency bed after procedure.

Seven-day services

- The surgical service provided a seven-day service, if required.
- 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 a surgical procedures seven-days a week. However, operating lists ran from 8am to 8pm weekdays and 8am to 5pm on Saturdays. Each operating list had a 15-minute slot allocated for a team briefing. Endoscopy lists ran from 7:45am to 6pm on weekdays and 7:45am to 4:30pm on Saturdays.
- 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.
- The pharmacy was open Monday to Friday 9am to 5pm and Saturday 9am to 2pm. Out of these hours the nurse in charge and RMO could access pharmacy for stock items. Medicines for patients to take home were stored on the ward or patients could have a prescription which could be taken to a specific local pharmacy.
- The physiotherapy department was staffed Monday to Friday, 8am to 6:30pm. In addition, there was a weekend rota to provide support to inpatients.

Health promotion

- **Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery and as appropriate for individuals.**
- 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 and increasing physical activity.
- 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 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.**
- 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 DoLS.
- The hospital had an up to date policy regarding the Mental Capacity Act 2005 and DoLS. Staff could access this on the hospital intranet.
- All new staff received MCA, best interest (BI) and DoLS training on induction. Focussed training has been delivered to all staff from July 2018 and the current training figures were 73%. Further training had been arranged for November and December 2018.
- Consent to care and treatment was obtained in line with legislation and guidance, including the MCA. Staff understood their responsibilities and the procedures in place to obtain consent from patients prior to undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and

signed authorised forms for treatment and exploratory investigation during the inspection. We observed consent being obtained for all patients prior to their surgical procedure.

- 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.
- Consent audits were carried out by the service every two months. The September 2018 results showed an overall compliance rate of 75% based on 30 records. The audit was RAG (red, amber, green) rated and percentages ranged from 13% to 97%. Examples included:
  - There is evidence in the medical/anaesthetic record, the anaesthetist has recorded their discussion with the patient about the risks, benefits and alternatives to their anaesthesia and their consent is documented (13%).
  - There is evidence in the patient record that significant, unavoidable or possible occurring risks have been discussed with the patient (97%).
- Staff told us that patients with complex needs would be involved in a pre-operative meeting with their family, friend, carer and consultant 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.
- Patients said they were given all the information they needed to decide about the treatment being provided. They said doctors had fully explained their treatment and additional information could be provided if required.
- Staff described when DoLS might be needed and staff provided us with examples of two incidents where they had made a made a DoLS referral. Staff explained that they would contact the head of clinical services and involve the consultant and relatives if they had concerns about a patient.
- During the inspection we looked at 24 records but none of the patients had a do not attempt cardiopulmonary resuscitation decision (DNACPR) form. However, staff explained the procedures and processes they would take should there be a DNACPR in place for a patient.

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) audit results for 2017 regarding privacy and dignity were above the national average of 84% at 98%.
- Woodland Hospital obtained feedback through many mechanisms including the NHS friends and family test. This information was reviewed monthly and comments shared and reviewed at the heads of department meetings. Patients were also contacted by telephone or letter to provide feedback regarding improvements which could be made to the services offered. We saw "We Value Your Opinion" questionnaires available on the wards which enabled the patient to comment on areas such as food, hygiene and cleanliness. There was also a free text section for patients to add any further comments relevant to their stay.
- The return for the patient satisfaction survey for August 2018 was low with a total of 51 respondents. However, 96% patients said that they would recommend the hospital to family and friends and 94% confirmed they were happy with the care provided. The two lowest

scores were; did a member of staff inform you of medication side effect (60%) and did the hospital tell you who to contact if you were worried about your condition or treatment after leaving (77%).
- Staff informed us that several improvements to the quality of service had been made in response to patient feedback and concerns which included a review of the telephone system to ensure patient calls were directed to the most appropriate person first time.
- The wards displayed many 'thank you' cards, which staff had received from patients and relatives.
- 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.**
- 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. One patient said, "staff are brilliant and always on hand to ask them anything." Patients also said that staff were "approachable" and "provided support when required."
- Staff understood the emotional stress of patients having an anaesthetic prior to a procedure. One patient said staff were very supportive and reassuring before their anaesthetic to minimise their anxiety and stress. 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 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.**
- 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.
- We saw staff greeting patients by their first name and patients calling nursing staff by their first name.
- 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.
- 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 hospital planned and provided services in a way that met the needs of local people.**
- There was an understanding of the different requirements of the local people the hospital served by ensuring that the needs of local people were considered through the planning, design and delivery of services. A variety of surgical procedures were available, including orthopaedic surgery and general surgery.

- The hospital only received planned admissions. Patients' specific needs such as learning disabilities, other disabilities or mental capacity issues were identified at pre-assessment, to ensure appropriate arrangements were made to meet individual patient needs prior to admission.
- 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 March 2016 inspection identified 0% compliance with the requirement to provide patients with written information prior to admission. The September 2018 patient journey audit identified 100% compliance based on 25 records. We did not see any issues or concerns in the records seen during this inspection.
- The hospital was committed to providing surgery to private patients as well as providing services for NHS patients through agreements with the local commissioners. All patients were treated equally whether self-funded, through insurance schemes, or through the NHS.
- 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 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 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. A staffing acuity tool was used to ensure that enough staff were on duty to meet the needs of patients.
- 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 and critical care services.

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 medical services.**
- 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.
- Services were mostly planned and delivered to take account of the needs of different people. Patients had access to the wards by lift where applicable, and the corridors were wide which meant there was easy access for wheelchairs.
- 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. Relatives needs were considered and we saw them offered food and drinks when they visited patients.
- The service's Patient-Led Assessment of the Care Environment (PLACE) audit for 2017, which looks at how the environment supports patients living with a disability scored 86%. This was higher (better) than the England average of 84%.
- The PLACE audit for 2017 for food and hydration showed they scored better than the England average of 91% at 95%.
- Details of food allergies and specific dietary requirements were forwarded to the catering team to

ensure they had the information and provisions to meet the patients' needs and ensure their safety. We spoke with catering staff who confirmed and showed us the processes in place when informed of a patient's specific dietary needs. During the inspection, there was no patient identified with specific dietary requirement.
- 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.

Access and flow

- **Patients could access the service when they needed and there was minimal waiting time for patients to have their procedure.**
- 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 and unnecessary cancellations were avoided where possible. 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 to respond to the increased complexity of patients being treated, with the aim of avoiding cancelling operations and providing an improved service. Briefing meetings in the operating department were introduced to complete final checks such as equipment orders to avoid cancellation of operations.
- There was a service 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.
- To improve the flow within theatres a "list" safety officer's role had been embedded. Their role was to manage the theatres list and they were identifiable through the wearing of a red hat. There had been 13 theatre over-runs from May to September 2018, of which five referred to the lateness of the anaesthetist/surgeon/staff, three regarding complications with the procedure, three for the timely completion of the list, and one for equipment and a patient being delivered late from the ward. Actions were overseen by the heads of department which included informing theatre staff of the importance of punctuality expectations.
- Staff confirmed they tried to avoid cancelled operations and rebooked any cancelled patients as quickly as possible. Procedures that were cancelled or delayed were recorded as a clinical incident and appropriate actions taken. We saw the theatre cancellation tracker and action log from January to October 2018. There had been a total of 8,529 operations of which 422 (5%) had been cancelled. Patient cancellation represented 282 (3.3%) and 44 (0.52%) for theatre cancellations. We saw all the entries on the action log had been completed except for the following which were on-going;
  - confirmation of appointments to be verbalised to ensure patient receipt, and
  - information to be checked to ensure the service was giving patients sufficient information.
- The hospital readmission rate provided was below the national average. Senior staff attributed the low rate of readmission to patients being given follow up procedures prior to their discharge and being provided with key information at the point of discharge about their care following procedure.
- The hospital reviewed those patients who were readmitted within 28 days of being discharged. Cancellations were rescheduled within 28 days and there was no distinction made between NHS and private patients.
- The number of unplanned readmissions within 28 days of discharge from April to June 2018, (for related condition) was three while there had been six unplanned transfers of inpatients to other hospitals. Any return to theatre was followed up with a review, to ensure lessons were learnt to influence practice going forward.

Re-admission rate 2016/17

- Hospital data showed that the readmission rate for patients was lower than the England average with 0.003 compared to 11.43 (England average) in 2015 to 2016 and 0.002 compared to 11.45 (England average) in 2016/2017.

Unplanned returns to theatre

- Hospital data showed that there had been a gradual increase in reoperations since 2015 with 0.11% recorded for 2015/16, 0.16% for 2016/17 and 0.18% in 2017/18.
- Patient waiting times were actively managed to review patient care pathways and patient waiting times to identify any themes or trends while ensuring patient waits were kept to a minimum and those service in high demand were managed appropriately. We saw patients had timely access to initial assessments and treatment. National waiting time targets for surgery was 92% and the service was consistently above the national target as outlined below.
- A weekly report was provided by the Ramsay corporate team highlighting waiting times which was managed locally in line with demand for services.

Waiting List by speciality (published October 2018)

- Hospital data showed that specialities were achieving over 98% of treatments within 18 weeks of referral. The average waiting time for treatments was recorded as between 4.4 weeks (for ear nose and throat specialities) and 7.3 weeks for dermatology specialities. General surgery provided 98% of pathways within 18 weeks with the average waiting time 4.8 weeks.
- Most day case patients left hospital on the day planned, which ensured a smooth flow of patients into and out of the service and we saw arrangements in place to assist patients who required unplanned further care following their procedure. Discharge planning started at the patient's pre-assessment appointment so that any specific needs could be met and planned for. There were systems in place for working with local social services and other agencies for those patients requiring extra support to be set up following their operation.
- The hospital analysed their theatre utilisation. Utilisation is used to review theatre efficiency and the service performance for surgeons. The hospital provided us with the theatre utilisation figures up to June 2018, which showed 83% for three theatres. The fourth theatre commenced procedures in September 2018 and the theatre's performance figures would be incorporated in the next analysis.

Learning from complaints and concerns

- **Complaints and concerns and complaints were treated seriously, investigated and lessons learned from the results, which were shared 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.
- We observed literature on display advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- Patients we spoke with told us they had not had a reason to complain during their stay, but they would feel confident in raising a concern or complaint if necessary. Staff said that if a patient raised a concern or wanted to make a complaint they would try to resolve it quickly at the point of service and where this was not possible the complaint was referred to the ward manager or nurse in charge. However, it was unclear if staff documented complaints resolved on the wards which meant that we could not be assured that all complaints were identified and recorded.
- From August 2017 and July 2018, 51 complaints had required further response following an investigation. The top three themes identified were administrative communication issues, clinical care by consultants, and consultant attitude and behaviour. All other complaints within the time have been fully investigated and the necessary actions had been taken to improve the quality of the care and service offered. We saw that complaints were discussed at clinical governance meetings and areas for improvement and learning were highlighted.
- We reviewed ten complaints files and saw that they generally referred to issues with consultant treatment plans and non-clinical topics such as car parking and appointment scheduling. There were two files which were significant enough to result in a local investigation and we were told that one was in progress, however the other was delayed as the patient's notes were requested from a local acute trust to confirm treatments given.
- We found that complaints files were generally well maintained, however in discussions we were told that the managing director or head of clinical services (matron) would often call the complainant upon receipt of the complaint letter. We found that these conversations were not routinely recorded or evidenced in the complaints files. This meant that the files did not contain all the information relating to the complaint, and potentially details of agreed actions or timelines.

This was raised during the inspection feedback and we were told that the service maintained a complaint spreadsheet that captured when telephone conversations were completed, however, the team acknowledged that this did not always happen.

- The management of complaints was shared across the senior leadership team and the person responsible for completing any investigations depended on the content of the complaint. For example, the managing director would investigate non- clinical complaints and formulate a response. The head of clinical services (matron) would investigate and respond to clinical complaints with the assistant of clinical specialists where necessary. It was unclear if the responses completed went through a quality assurance process, and we saw that there were some grammatical errors or incomplete sentences in the samples of patient responses provided for this inspection.
- We spoke with the medical advisory committee lead who acknowledged that complaints relating to clinical practice and consultant performance were reviewed at the MAC meetings. We were told that meetings would discuss themes and actions and not necessarily the detail of the complaint, particularly in relation to staff names or specific investigations. The MAC discussed the complaint and sought confirmation of best practice from the specialist lead on how they should be managed. Meeting minutes confirmed this.
- We saw that complaints were discussed with the wider teams and there were learning events completed to share learning and identify areas where performance could improve. There was a "learning from complaints and feedback" news-sheet which identified complaint themes, actions taken in response to concerns raised and general feedback about services.
- There had been 25 complaints reported from January to June 2018, with administration processes, procedure complications/ concerns relating to consultant care and patient information/ communication being the three main topics. Actions taken in response to concerns raised consisted of new telephone handling system, review of administration processes, review of information provided to reduce cancellations and queries, and complaint sharing events with the consultants' service leads told us they had made an effort to improve responses to complaints and were investing in capturing feedback from patients and their relatives. Over the four months prior to inspection the leadership team were also addressing concerns in a timely manner in other forums such as NHS Choices and "hot alerts".
- Patients were offered apologies and compensation when billing errors occurred. Staff had been reminded of the importance of information governance and maintaining patients' records when information between providers, was not effectively communicated.
- Staff told us new complaints and learning from complaints were discussed at their team meetings or areas for learning shared on the "WhatsApp". WhatsApp is a messaging available on mobile phones. We reviewed the minutes from monthly clinical governance team meetings, medical advisory committee meetings and heads of department meetings that demonstrated complaints were a regular agenda item.
- The hospital director was responsible for overseeing complaints. The procedure for dealing with complaints was reviewed in June 2018. The senior leadership team discussed complaints at their weekly meetings. Complaints and feedback was also discussed at local team meetings and issues discussed and shared with the teams.
- The corporate protocol advised that acknowledgement was to be made within two working days and a full written response within 20 working days. A holding letter would be sent to the patient if there was a delay in the response time such as the gathering of information or the requirement of a statement from consultants or staff.

Are surgery services well-led?

Good

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

Leadership

- **The hospital had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care. They understood the challenges to quality and sustainability such as financial pressure and bed capacity.**
- The service was part of the Ramsay Health Care UK Operations Limited group. The hospital senior management team reported to the corporate leads and

were supported through a network of regional and national leads and specialists. Staff confirmed that corporate support was readily available, and that relationships were robust.

- The service senior leadership team consisted of a hospital director, head of clinical services (matron) and finance lead. There had been a number of changes to the senior team structure over the last year with changes to the hospital director post and the decision to remove the operations manager post when it became vacant. The new hospital director had been in post approximately four months prior to the inspection and they confirmed that the operations manager post would not be recruited to, and that the senior team was complete. It was clear from discussions with the team that the working relationship between hospital director and head of clinical services (matron) was robust and offered the wider team stability. Staff were enthusiastic about the style of leadership and were optimistic that things were improving.
- The senior leadership team had clear ideas of where they wanted to develop services and where they needed to focus to make improvements. Although it was not clear that these were part of a formal action plan, the hospital director was in the process of stabilising the workforce and preparing the team for future developments.
- Internal support for the hospital director consisted of the finance lead, and a number of administrative staff including HR coordinator, patient/ GP coordinators and business / administrative managers. The head of clinical services (matron) was supported by the quality improvement coordinator and heads of departments for each clinical area. Due to the size of the service, staff reported that leads were visible daily and regular contact was maintained through an informal and formal process. The leadership team were in the process of embedding new systems of working and setting the culture.
- Leadership of the medical advisory committee (MAC) was under review at the time of inspection. The MAC lead had been in post for several years and the policy was for renewal every three years. Service leads had opened the invitation to consultants at the hospital to apply for the position, and were enthusiastic that a successful candidate would be identified.
- Staff said the executive director was well respected and visible. Nursing staff also said that the head of clinical services (matron) and head of clinical services were always available and supportive.
- Staff told us that they enjoyed working in the department and felt supported by their departmental managers. Department managers told us that they had an open-door policy and that they spoke with pride about the work and care their staff delivered daily. Many clinical staff working on the wards had worked in the organisation for over 10 years. They told us they had stayed in the organisation for a long time because of the team they worked with.
- 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.
- All grades of staff in the service told us they thought managers were approachable. The managers worked clinically and provided clinical cover for sickness when required. We saw that ward and theatre staff worked well together.
- 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 hospital had a vision and strategy 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.**
- 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 Northamptonshire and surrounding areas
  - Become the health care employer of choice.
- On an annual cycle, Woodland Hospital developed a clinical strategy which set objectives for the year ahead. We saw the clinical strategy for 2018/2019 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.
- We saw posters on display throughout the hospital outlining the hospital's values and vision. Most staff we spoke to at all levels were aware of the hospital's strategy and knew how to access the information on the hospital's electronic system.
- We were told that a number of staff had been involved with the development of the local vision and strategies as part of workshops. These included off site meetings run by the senior leadership team.
- The service vision referred to the establishment of "strategic partnerships with local, national and global stakeholders to be the trusted provider of choice to deliver excellent, affordable care to all patients with the best team in the sector". Whilst the vision was published, it was not clear if all staff were familiar with the vision and staff did not report being involved with its development.

Culture

- **Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Nursing staff on the wards reported a good culture. Staff felt supported by their colleagues and head of clinical services (matron) 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 head of clinical services (matron) and ward managers. The head of clinical services (matron) 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 head of clinical services (matron) and managers.
- 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.
- The clinical service lead for nursing in the service held regular meetings with department managers.
- The hospital had launched the "speaking up for safety" (SUFS) programme in July 2018. The SUFS was launched at the hospital, 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 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.
- 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.
- Ramsay Health Care had a freedom to speak up guardian. However, most staff spoken with were unaware of who the freedom to speak up guardian and most were unaware of how to obtain their contact details if required.

Governance

- **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.**
- The hospital had a clear governance framework in place with a variety of sub-committees including training education and development, infection prevention and control and risk management feeding into the clinical governance and medical advisory (MAC) committee meetings.
- There were arrangements in place to ensure that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely and relevant. However, these were not always effective. It was unclear what oversight the hospital had on some aspects of safety, risk and governance.
- We reviewed three sets of governance meeting minutes and saw that they were well attended by the senior management team, heads of department and clinical

leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks. However, minutes were not always detailed so the depth of discussion at meetings was unclear. For example, the review of complaints, audits and the actions taken. This meant that we could not be assured of the oversight by the clinical governance and MAC committees.

- The MAC was chaired by one of the consultants with practising privileges and received reports from all the other committees. The MAC would review medical staffing practising privileges, discuss audits, and any new procedures that were to be undertaken to ensure they were safe. Complaints and learning from incidents was also discussed.
- 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 senior leadership team (SLT) had introduced a monthly performance review for each department. We saw that the head of department (HoD) was responsible for completing a monthly report which looked at areas of performance including key performance indicators, complaints and incidents. The report also detailed staffing concerns/ vacancies and sickness management, training performance and the review of the local risk register. The SLT reported that these meetings were designed to be led by the HoD and was an opportunity to discuss what particular areas they wanted to focus on. The meetings were developing as the HoDs became more familiar with the process.
- All consultants applying for practising privileges were required to provide evidence of appropriate and adequate indemnity insurance. The consultants' handbook set out what the hospital's minimum consultant medical malpractice indemnity requirements were.
- The hospital had processes in place to ensure that medical professionals granted practising privileges maintained an accurate personal record and appraisal record in line with General Medical Council (GMC) requirements of registration. This process was managed by the executive director with input from the MAC when required.

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. However, there were not always effective oversight of some aspects of safety, risk and governance.**
- All risk assessments were entered onto the risk assessment log and those having a score over nine were entered into the local risk register. The risk register was discussed at all committee meetings. After every review or update the version was updated to ensure the sharing of information with the corporate team.
- 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 theatres the unavailability of equipment within theatres which could impact on the theatre listing was not included in the risk register. The manager said this was a regular occurrence. However, the new manager confirmed they had not had the opportunity to review the risks and confirmed they were working with the theatre action plan to ensure all identified areas of concern were being addressed.
- There were 26 risks identified on the hospital risk register. These referred to clinical and financial risks such as medical notes, post-operative infections, mandatory training and building 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.
  - Orange- risk scores nine to 14.
  - Red- risk scores 15 to 25.
- We found that the risk register did not always accurately describe the risk score. There was one risk identified as being red, which related to medical records and the remaining 25 risks were identified as orange. We saw that one orange risk was incorrectly calculated and should have been identified as red, this related to the non-completion of fire risk assessment action plan.

- We saw that the risk register was not always updated when it was reviewed. For example, there were nine risks identified with a monitoring phase identified as being "ongoing" and they were recorded as last being reviewed in May 2018. Two of these risks were also identified as being at an increasing risk at that time, and should have been reviewed more frequently. The minutes from the risk management group meetings were shared with us, and we saw that they contained little information relating to discussions or actions taken, and concentrated on risks that were to be added or removed from the risk register. There was no evidence of the ongoing review of risks remaining on the risk register.
- Despite the lack of documented reviews, we were assured that risks were discussed regularly. The SLT were fully aware of their risks and actions that had been taken to mitigate them. We were told that the issues identified had been an oversight and that the risk register had been updated following our inspection.
- An annual health and safety risk management review took place. The review analysed data relating to all topics relating to health and safety which included incidents, fire drills, training and occupational health. The report resulted in an action plan which included training on incident reporting and mandatory training, in addition to actions relating to reviewing the risk register.

Managing information

- **The service collected, analysed, managed and used most information well to support all its activities, using secure electronic systems with security safeguards.**
- There was a wide range of information available to enable managers and service leads 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. Heads of departments were held responsible for their actions and teams' performance.
- The hospital produced a monthly patient journey report which listed their performance. This was based used 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.
- Staff confirmed they received information in a variety of methods which included; team meetings, newsletters, notice boards and the "WhatsApp" mobile telephone system.
- Nursing and medical patient records were combined within the same record. This meant that all health care professionals could follow the patient pathway clearly.
- 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.

Engagement

- **There was engagement with patients, the public and local organisation to plan and manage appropriate services, and effective collaboration with partner organisations.**
- Staff engagement had improved since changes to the senior management team. Staff sickness levels were reduced and all staff reported positive changes.
- There was a proactive approach in forging working relationships with external providers and agencies. For example, the local Health watch and Clinical Commissioning Group had been invited to attend the hospital to review different aspects of the service. Senior leads also spoke about working with the local acute hospital to improve relationships and identify areas where they could assist. It was acknowledged that there was work to do to improve relationships with some external services, however, the leads were optimistic that effective partnership working could be developed to improve patients' experiences.
- 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.
- The Woodland Hospital FFT patient satisfaction scores continually achieved over 97% for "would recommend to others". This was consistent with other local private hospitals.

- The senior leads had introduced a post admission telephone call to capture any initial feedback. Patients details were held in a file and an allocated nurse would contact the patient by telephone. Patients were asked to give their feedback about the service which was then noted and escalated to the SLT. We were told that in addition to the feedback, this process also enabled patients to speak to a nurse and ask any queries about their recovery.
- Staff surveys were undertaken and the hospital director shared the results with staff in an open forum to provide an opportunity for staff to shape change. Feedback from discussion from the forums went to an employee engagement group. This group discussed survey results, hospital issues and updates, and the working environment, and was attended by a member of the senior executive team and a representative from each department.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things go well and when they go wrong.**
- During the inspection, we found areas of concern that were highlighted in our March 2016 inspection and had not improved. For example:
  - The hospital had not ensured that all risks were identified, reviewed regularly and timely actioned.
  - The hospital had improved the review and sharing of information regarding complaints. However, during this inspection we found that conversations were not routinely recorded or evidenced in the complaint files which meant that records did not always contain all the information relating to the complaint.
  - The hospital had devised clinical audits to monitor service improvements. However, not all audits had identified action plans which meant that we could not be assured there was oversight of service improvements.
- We saw areas of improvement, which included:
  - Systems in place to ensure emergency equipment and medicines were safe and fit for purpose.
  - The hospital had addressed concerns within theatres regarding dress codes. We found no issues or concerns during this inspection.
  - The hospital had implemented a time out procedure before commencing surgery
  - The hospital had developed the role of the “list” officer to manage the changes to operating lists
  - The hospital monitored patient waiting times in response to patient feedback received to improve patient experience.
  - A major incident scenario had been undertaken in line with Ramsay Health Care policy.
- Staff felt they could approach other experienced staff for advice and support when required. Staff felt 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 are maintained throughout the hospital.

Good

Outpatients

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

Are outpatients services safe?

Requires improvement

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.

Our rating of safe went down. We rated it as **requires improvement** because:

Mandatory training

- **The service provided mandatory training in key skills to all staff, but not all managers had processes in place to monitor compliance and ensure everyone completed it.**
- Staff we spoke with us told us that they had completed their mandatory training requirements and were up to date. All staff held a training passport, which had recently been introduced, that identified their training requirements and compliance with this.
- Mandatory training was a mixture of online and face to face learning. Face to face learning topics included fire safety, basic life support and immediate life support, manual handling, blood transfusion, infection control, aseptic non- touch technique (ANTT) and hand hygiene, 'riskman' (incident reporting), and safeguarding. Online learning topics included good communication and person-centred care, factual information on dementia, emergency management and fire safety, equality and diversity, health and safety and infection control
- Staff told us that mandatory training sessions were held each month in order for staff to update on required training modules.
- One manager reported that there was an electronic system for monitoring staff compliance with training requirements. They told us that this was reviewed regularly, and compliance levels were reported to senior managers at governance meetings. In addition, this manager explained that all staff had a personal folder which documented their compliance with training requirements. However, another manager said that training compliance information was sent to them approximately every two weeks and did not describe having access to an electronic system for information. The hospital told us that a training, education and development coordinator monitored training compliance monthly and shared a compliance report with all heads of department monthly. However, we were not assured that all managers were clear about this process or had oversight of training compliance within their own departments.
- We asked for current compliance rates for mandatory training in outpatient services. The hospital could not provide service level data for face to face training modules but told us that for eLearning modules there was 84% compliance for staff in the outpatient department and 92% for staff in the physiotherapy department.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse and knew how to apply it.**

Good

Outpatients

- Safeguarding training data for the outpatient service was not available, although hospital wide data showed that compliance was between 91 and 100% for all staff groups. Full details of training compliance can be found within the surgery report.
- Safeguarding adults and children policies were in-date and were accessible to staff through the hospital's intranet. They included clear guidance on how to manage suspected abuse and radicalisation, and details of who to contact for further support and guidance
- Staff were able to name the safeguarding leads for the hospital for both adults and children's safeguarding.
- Most staff we spoke to told us they had completed safeguarding training level two for adults and children and were able to describe what would constitute a safeguarding concern. Staff described an escalation process for safeguarding concerns through their manager or the safeguarding lead. Some staff were able to give us examples of when they had reported a safeguarding concern to the local authority.

Cleanliness, infection control and hygiene

- **The service did not always control infection risk well. Staff did not always keep themselves, equipment and the premises clean. They sometimes used control measures to prevent the spread of infection.**
- We saw that all clinical areas and clinic rooms had hand washing facilities with sensor or elbow-operated taps. There were hand washing technique posters displayed above the sinks. During our observations of clinical care, we saw that staff usually followed hand hygiene procedures and were observed to be bare the elbow in line with the hospital infection control policy.
- Hand gel dispensers were located throughout the clinical areas and waiting areas with visible signage to encourage staff and visitors to use them. Staff told us that hand hygiene audits were carried out. Results of the last hand hygiene audits carried out across the hospital showed that compliance was 70%. In the outpatient's department the hand hygiene audit data for September 2018 showed 50% compliance. There was no action plan in place to improve compliance. In the physiotherapy department the hand hygiene audit data for September 2018 showed 88% compliance.
- We saw that personal protective equipment (PPE) such as disposable gloves and aprons was available, and that staff used this appropriately.
- Staff told us that there was an infection prevention control lead in hospital who could offer specialist advice and support on infection prevention control issues.
- During our inspection, we observed a minor operations procedure and saw that is was carried out in a sterile way in accordance with policy and procedure.
- We noted that all furniture, such as chairs and treatment couches, were made of wipeable material. There were antiseptic wipes in each clinical room which we observed were used to wipe down couches after each new patient use. Paper roll dispensers were in clinical rooms and we saw that fresh paper roll was placed over couches before each new patient used them. All waste disposal bins in consulting rooms and clinical areas were pedal operated bins which supported the safe management of health care waste in adherence with infection control guidelines.
- Disposable privacy curtains were in place around treatment couches which were dated to indicate when they had last been changed. We noted that most had been changed within the previous month.
- 'I am clean' stickers were not routinely used in all areas, to indicate that equipment had been cleaned and was ready for next use.
- We saw that dust covers were in place to protect some clinical equipment and keep it clean and dust free. However, we did find that a suction unit in one of the treatment rooms had a thick layer of dust on it. We escalated this to the manager who took action to remedy it.
- Managers told us that daily cleaning schedules were in place for each clinic room. A system had recently been put in place for named nurses to have responsibility for specific clinic rooms, which included the cleaning and equipment stocking of the rooms at the end of each day. A process for documenting and monitoring this was under development. In addition, housekeeping staff followed a cleaning checklist for clinic rooms which was completed each morning and included cleaning sinks, washing bed frames and emptying bins. We saw that there was a daily signature sheet to evidence that this had been completed and noted that it had been consistently completed.
- Staff in the physiotherapy gymnasium told us that there was a process for all equipment to be wiped down on a daily basis and this was recorded on a tick sheet.

However, there was not a system in place for cleaning of equipment between each new patient use. This meant that there was a risk of spreading infection between patients.

- We noted that some clinic rooms had carpeted floors, although staff told us that there was a programme to replace all carpets in clinic rooms which was due to be completed by December 2018.
- We saw that in the dirty utility area there was some equipment used for applying and removing plaster casts and some sealed clean bandages. There was no evidence that the equipment was clean and ready for use and we were concerned that clean dressings and equipment were being stored in a dirty utility area. This was raised with the nurse in charge who immediately took action to address this.
- In the clinical store rooms, we saw reusable endoscopes in sealed packaging that would indicate they were clean but there was no date to show when they had been cleaned and it was unclear if they were fit for use. This was not in line with recommendations for JAG accredited providers. These endoscopes were used in the treatment rooms for ear, nose and throat assessments. We asked several nursing staff about when the endoscopes had been cleaned and if they were ready for patient use but they were unable to find this information. The scopes were therefore removed and sent for cleaning to ensure they were fit for use.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well. However, we were not satisfied that there was a consistent oversight process for equipment maintenance.**
- Access to the outpatient department was through the hospital's main entrance, which had ramped access. Outpatient services were delivered on the ground floor of the building.
- The physiotherapy service was housed in a separate building which had level access. There was a small waiting area and a reception desk. Access to the clinical area was through a staff swipe card system.
- There was a resuscitation trolley in the outpatient department and an emergency 'grab bag' plus a defibrillator, suction unit and oxygen cylinder in the physiotherapy department. We saw that daily and weekly checks were carried out on resuscitation equipment in accordance with policy and that this was recorded. We noted that checks had been completed for each working day from July 2018 to October 2018. However, there was no section on the checklist in physiotherapy to document that the suction machine had been checked. This was raised with the staff member at the time, who agreed to raise this with the resuscitation lead for the hospital.
- We reviewed stock of clinical treatment items in the clinic rooms and store rooms and found that all the items we checked were in sealed packaging and within their expiry date.
- We saw that there were sharps bins in each clinic room and these were dated and not overfilled beyond the fill line.
- Pathology and histopathology services were not provided on site but were outsourced. Nursing staff told us that there was a process for sending and tracking of histopathology specimens which were sent off site for analysis. We reviewed the log to track specimens and found that there was not a consistent process for tracking all specimens, as some results had been returned but there was no log of the specimen having been sent. This meant there was a chance that some results could go missing as there was no way of chasing outstanding results if there was not always a record of the specimen being sent.
- During inspection we found several items of battery operated and electrical clinical equipment that were overdue their testing date or that did not have a sticker to indicate the date on which they were last tested. We raised this with managers on site and asked for assurance that equipment was safe for use. One manager told us that there was an equipment maintenance log but another manager seemed unaware of a log. After our inspection we asked to see copies of equipment maintenance logs and saw that they existed for the outpatient and physiotherapy departments. We noted that most equipment was in date for testing. However, it was not clear whether there was a system across departments for monitoring compliance with equipment maintenance requirements. We asked for information about any systems and were told that contractors responsible for equipment maintenance contacted the hospital's maintenance team monthly with updates on servicing completed. The maintenance team updated the information on the equipment maintenance logs. We were told that there was a plan to share equipment

compliance records at health and safety meetings going forwards, but this oversight process was not in place at the time of our inspection. We were not satisfied that there was a consistent oversight process for equipment maintenance.

Assessing and responding to patient risk

- We saw that there was a hospital wide emergency call bell system in place, which meant that if a call bell was activated in any department, a team of staff would treat it as an emergency and respond immediately. We were told that the call bell system was tested on a weekly basis.
- There were clear processes and pathways for the assessment of people within outpatient clinics who became clinically unwell. Nurses in the outpatient department told us that if a patient became unwell during their appointment, they would carry out vital signs observations and document these on a national early warning score (NEWS) form. Deteriorating patients would be assessed by the resident medical officer who could be called from the ward. In an emergency situation, staff would call 999 for assistance and transfer unwell patients to an acute hospital if necessary.
- There were plans in place for local implementation of the national safety standards for invasive procedures (NatSSIPs). There were NatSSIPs guidelines displayed on a poster in the treatment rooms and staff told us that they followed the guidance during minor operations procedures.
- Staff did not have access to specialist mental health support if they were concerned about risks associated with a patient's mental health. Staff told us that they would refer patient's back to their GP if they had concerns about their mental health.

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.**
- Managers and nursing staff in outpatients told us that there were enough staff working in the department to meet patient needs.
- Data provided by the hospital showed that there were 8.2 full time equivalent registered nurses and 3.7 full time equivalent health care assistants in post working in the outpatient's department. The manager told us that staffing rotas were produced six weeks in advance to ensure that adequate staffing was available to cover the activity levels planned in clinics. During the reporting period from August 2017 to July 2018, the service reported between 2% and 11% bank registered nursing staff usage and between 0% and 2% bank health care assistant usage to cover shifts. The service reported that there had been no use of agency staff during the reporting period. The service did not report any unfilled shifts.

Allied Health Professional staffing

- Staffing data for the physiotherapy department showed that there was one full time equivalent vacancy for a physiotherapist, which had been recruited to. Registered physiotherapy staff were supported by three physiotherapy assistants and eight bank physiotherapists who worked as and when necessary to complement activity.

Medical staffing

- There was a total of 112 medical staff employed within the hospital under practising privileges rules. These staff worked across the outpatient department and inpatient wards. In the outpatient department medical staff delivered clinics for specialities which included orthopaedics, urology, gynaecology, general surgery, ear nose and throat, gastroenterology, ophthalmology, audiology, cardiology, cosmetic surgery, dermatology and rheumatology.
- See information under this sub-heading in the Surgery Report section.

Records

- **Staff did not always keep appropriate records of patients' care and treatment. Records lacked detail and were not always signed and dated by staff. There were occasions when records were not available to all staff providing care. However, a new system had been implemented in August 2018 to ensure all patients had a set of records held at the hospital.**
- We reviewed five sets of records in the outpatient department and saw that they generally consisted of a clinic letter without any running records. Staff told us that consultants would dictate a letter following a clinic attendance which would be added to the patient's

record folder once typed by the secretaries. However, in four of the records we reviewed there was no entry in the records to indicate that a patient had attended the clinic. When nursing staff or health care assistant completed any assessments or observations we did not see evidence of them being documented. Nursing assessment tools were not routinely used.

- We looked at 28 sets of outpatient care record pathways for patients who had undergone minor surgery. These records were being stored in a folder in the nurse's office and it was unclear why they had not been filed in the records storage department. The records consisted of outpatient procedure care pathway documents which detailed the procedure, surgical checks in line with the world health organisation (WHO) safe surgery guidelines, and documentation of consent. We found that these were generally not well completed.
- Record keeping audit results of outpatient record sets in September 2018 showed an overall compliance of 83% against record keeping standards.
- In the physiotherapy department we reviewed six sets of records and saw that the records booklets used to document assessment and treatment were incomplete in four cases. Omissions included non-completion of patient details such as medical history and medication, failure to complete pain assessment tools and outcome measures, and no completion of treatment plans and identified goals. Not all records were consistently signed or dated on each page.
- Record keeping audit results of physiotherapy record sets in September 2018 showed an overall compliance of 87% against record keeping standards.
- Staff in the records department had an electronic tracking process for when medical records left the department and were transferred to the outpatient department or the ward.
- Medical records were stored securely in a room with swipe card access. Any records transferred to the outpatient department were collected on a daily basis to be returned to the secure storage room at the end of each day.
- Physiotherapy records were kept separately in the physiotherapy department. All records were paper records and were stored in a locked filing cabinet at the reception area within the department.

Medicines

- **Staff in the service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.**
- Medicines were stored securely in the outpatient's department. Medication was stored in either a locked cupboard or a locked fridge. All items we checked were found to be within their expiry date. We saw that room and fridge temperatures were monitored and recorded. We found that temperatures were kept within range in accordance with policy.
- There was a pharmacy on site at the hospital which supported the inpatient and outpatient departments. It was open Monday to Friday 9am to 5pm and on Saturdays 9am to 2pm. Heads of department, the head of clinical services (matron) and the resident medical officer had access to an emergency dispensing box out of pharmacy hours.
- Managers told us that prescription pads were kept in the pharmacy in a locked file. Staff could request packs of 30 prescriptions which included a log of when they had been used and by whom. Any unused prescriptions were returned to the pharmacy at the end of each month.
- See information under this sub-heading in the Surgery Report section.

Incidents

- **Staff in 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 saw that there was a Ramsay healthcare UK group policy for incident reporting, which was in date. The policy identified individual's responsibilities for reporting and investigating incidents. All staff we spoke with were able to describe when they would report an incident and the process for doing so. Almost all staff had access to an electronic reporting system, although some administrative staff told us that they had to report incidents through their manager as they did not have access to this system.
- The hospital provided data for numbers of reported incidents across the outpatient services. During the reporting period from August 2017 to July 2018, there

were 48 clinical incidents, of which 37 were classified as no harm, and 11 as low harm. Key themes identified were around cancellation of appointments, incomplete documentation and medication errors. There were no never events or serious incidents reported in the outpatient department during the reporting period.
- Staff told us that they received feedback from incidents reported at quarterly shared learning forum events which all staff were invited to attend. We saw presentations from these meetings which showed that learning from serious incidents and never events reported across the whole hospital was shared. Managers told us that they discussed any incidents reported within their own departments at monthly staff team meetings.

Safety Thermometer (or equivalent)

- **Staff in the service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. This information to improve the service.**
- Hospital wide data showed that there were no reported incidents of MRSA, E-Coli or C. diff during the reporting period.
- The hospital was part of a Ramsay wide campaign called the 'speaking up for safety' programme. This was an education programme aimed at empowering staff to speak up and check the actions of colleagues where they had concerns about practise.

Are outpatients services effective?

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 inspected but not rated.

We currently do not rate effective for Outpatient Services.

Evidence-based care and treatment

- **Staff in the service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- We saw that NICE guidelines were followed in outpatients and physiotherapy. For example, the National Safety Standards for Invasive Procedures (NatSSIPs) were displayed on a poster in the treatment rooms and staff told us that they followed the guidance during minor operations procedures. In physiotherapy, the manager gave us the example that staff followed NICE guidance for the management of back pain. Managers told us that they were sent any newly published NICE guidelines for review and consideration of whether changes in clinical practise should be implemented.
- There were clinical policies in place which had standard operating procedures (SOPs) for staff to follow to ensure policies were adhered to. We saw that the policies and SOPs were referenced to national guidelines, journal articles and nursing and midwifery council standards meaning that services ensured they implemented best practise.
- There were regular audit processes such as record keeping, hand hygiene and environmental audits, which took place in accordance with an audit calendar. We requested results of audits and saw that these occurred in accordance with the calendar. A quality improvement lead collated the results of all audits which were presented at the hospitals governance and heads of department meetings. Audit results provided following our inspection showed that in October 2018 there was between 83% and 94% compliance with environmental and operational audit standards.
- Audits of clinical practises were not routinely undertaken in the outpatient or physiotherapy departments.
- We heard that physiotherapy staff had access to special interest groups where current and best practise guidance was shared through websites, newsletters and meetings.

Nutrition and hydration

- The outpatient waiting area had hot and cold drinks available forpatients and relatives visiting the department.
- See information under this sub-heading in the Surgery Report section.

Pain relief

- Patients attending for appointments were outpatients and only required analgesia if they were undergoing

minor surgery procedures in the outpatient department. We saw that local anaesthetic was routinely used to ensure that patients did not experience unnecessary pain during minor surgery procedures.

- We saw that visual analogue scale tools were available to assess pain in the physiotherapy department, however, we noted that the use of these scales was not consistent.
- See information under this sub-heading in the Surgery Report section.

Patient outcomes

- **Staff in the service did not routinely monitor the effectiveness of care and treatment. There was no consistent process to collecting outcomes information or using the findings to improve them.**
- There was no evidence of collection of any outcome data in the outpatient department as staff told us that this was done in the pre-assessment clinic as part of a patient's surgical journey. Information about the outcomes of people's care and treatment was not routinely collected and monitored for those patients attending clinics who did not require surgical treatment.
- In the physiotherapy department, the manager told us that there was a standard outcome tool used across the Ramsay healthcare UK group. This tool, the musculoskeletal health questionnaire (MSK-HQ), was a validated patient reported outcome measure that could be used to evaluate the health status and monitor change in patients with a range of musculoskeletal disorders. However, when we asked for data to evidence use of the tool, we saw that it was not consistently completed as a before and after outcome measure of care. We noted that the physiotherapy records booklet had sections to record objective and subjective markers and outcome measures, but these were generally not completed. We asked if any other outcome measures were used, and were told that staff did not routinely use additional outcome measures and that data from any other tools used was not routinely collated or reported.
- We did not find any evidence of participation in research or national clinical audits in the outpatient services.

Competent staff

- **Managers made sure staff were competent for their roles. Managers appraised staff's work performance although they did not hold regular supervision meetings with them.**
- All staff we spoke with told us that they had received an appraisal from their manager. However, data provided by the hospital showed that for the appraisal year 2017 (January 2017 to December 2017) 78% of registered nurses and 95% of health care assistants had received an appraisal. For the current appraisal year to date (January 2018 to December 2018), 82% of registered nurses and 100% of health care assistants had received an appraisal. This data was for staff working in the outpatient and diagnostic imaging services.
- Additional training needs were discussed as part of the appraisal process and learning needs were agreed and set during the process. There were in service training sessions provided for physiotherapy staff and some staff told us that they had been funded to attend external courses in order to develop their knowledge and skills.
- Most staff we spoke with told us that formal one to one or supervision meetings were not common place. Staff described some adhoc arrangements for supervision and support but not a process of documented, regular, formal supervision meetings. However, staff told us that their managers were available and they could approach them with problems or concerns at any time. Managers described other forms of supervision activities which took place, such as observation of clinical practise, case study reviews and weekly team huddles, although they told us that there was no documentation of any of these activities. There was a hospital clinical supervision policy which stated that all staff should receive supervision. The policy described a range of different types of supervision activities and recommended that both supervisees and supervisors kept a record of supervision activities. Since staff did not routinely receive or document supervision sessions, we were not assured that the clinical supervision policy was being adhered to.
- The physiotherapy manager told us that staff worked to competencies in their roles. These were achieved through a range of development opportunities such as training, and shadowing. Once achieved, staff were able to perform tasks within their competency base independently. For example, a physiotherapy assistant described a range of activities that they had been trained to do and other tasks which were not within the

scope of the competence for their role. Physiotherapy staff had personal folders which documented their compliance with an annual appraisal, a log of any additional training completed and provided a signed record of achievement of competencies.

Multidisciplinary working

- **Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- Most staff we spoke with told us that they worked well together as a team.
- We heard that there were fortnightly multidisciplinary team (MDT) committee meetings held between the orthopaedic surgeons, anaesthetists and physiotherapists. At these meetings, the MDT discussed any patients where there were pre-operative concerns such as risk factors, and made a joint decision about the next plans for these patients. The outcome of the MDT was recorded on a form with an action plan which may involve deferring surgery, seeking specialist opinions, or referring patients that were unsuitable for surgery back to their GP.
- Managers told us about partnership working across the Ramsay hospital group. They described quarterly cluster meetings, where heads of department would meet with others in the region in order to share ideas and work together on consistent approaches to the delivery of care across the Ramsay group.

Seven-day services

- Outpatient clinics were held between the hours of 8am and 8pm, Monday to Friday, and from 8am to 4pm on Saturdays. Clinics were not held on Sundays.
- In the physiotherapy department, appointments were available between 8am and 6.30pm Monday to Friday and sometimes on Saturdays. Staff told us that Saturday appointments were available once or twice a month depending on the member of staff working on the weekend rota. Staff worked weekends to provide cover to the wards. If the staff member normally worked in physiotherapy outpatients, they could offer appointments to patients on Saturdays.

Health promotion

- We saw that there were a range of information posters and leaflets available to patients to promote health and wellbeing. For example, we saw information advertising patient open evenings regarding management of back and neck pain, women's health, and management of shoulder pain. These open evenings could be attended by any member of the general public and were free of charge.
- There was a range of information leaflets in the physiotherapy department which promoted independence and encouraged patients with long term conditions to remain fit and active. Other leaflets provided advice on living with conditions such as arthritis and symptom management.
- Physiotherapy staff provided written information in the form of exercise programmes, that they recommended patients to follow in order to improve their symptoms or level of function.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. However, not all staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Not all staff had completed mental capacity act update training. Processes for documenting consent for minor procedures were inconsistent and consent was not always documented.**
- Outpatient care pathway documents for minor procedures were not consistently signed or dated to indicate consent. There was a checklist to tick on the pathway documents to indicate that consent had been provided, but in five out of six records stating that written consent had been gained, we found no evidence of this. Nurses told us that the consent forms could be filed in the patient records held in the records department. However, when we checked, four of the six patients did not have a record set, one had records, but no consent form and one had records that included a consent form. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for consent.
- Staff we spoke with during inspection, told us that if there were any concerns about a patient's capacity to consent to a procedure, a mental capacity assessment would be carried out. We saw that mental capacity assessment forms were readily available in all clinic

rooms, although not all staff were trained to complete mental capacity assessments. Where capacity to consent was unclear, procedures would be postponed in order to establish if the procedure was in the patient's best interests.

- We saw that there was a consent policy which was in date and identified responsibilities and processes for gaining consent for procedures, including minor operations. However, we found that there was a lack of consistent completion of written consent documentation. In five out of six records we checked, they stated that written consent had been gained, we found no evidence of this.
- In physiotherapy staff told us it was procedure to seek written consent for acupuncture treatment and we saw a policy and standard operating procedure which confirmed this. We asked for data from any acupuncture consent audits and saw that in September 2018, there was 100% compliance with an audit against the Chartered Society of Physiotherapy (2012) quality assurance standards audit tool for acupuncture.
- We asked staff if they had received mental capacity act training and most staff told us they had not received any training since their induction. The hospital told us that the safeguarding training delivered during the new starters induction programme included a session on mental capacity act (MCA), best interest (BI) and deprivation of liberty safeguards (DoLS). The hospital reported that there was a programme to deliver focused MCA training in place since July 2018 which 73% of staff had completed at the time of the inspection.

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.

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

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed staff interacting with patients and relatives and saw that they introduced themselves and were courteous and respectful. We saw a member of the reception staff assist a patient who was in the wrong place for their appointment; they took time to provide support to get them to the correct location. We listened to staff in the booking teams on the telephone who were professional, helpful and understanding when changes needed to be made to appointment times.
- In the physiotherapy department, we saw staff members provide encouragement to patients and show a supportive attitude during therapy treatments.
- All patients that we spoke with reported that staff were friendly and helpful.
- We saw that patient's privacy and dignity was generally respected. Clinic rooms were lockable and had engaged signs on doors. Privacy curtains were drawn around treatment couches when physical examinations were performed. Chaperones were available and we saw clear signage advising patients of their right to request a chaperone during appointments. However, we noted that the reception area where patients booked in for outpatient appointments did not have a privacy line or sign requesting that patients stand back to respect privacy of others. This meant that conversations held at the reception desk were not private as they could be overheard by others. Although these conversations did not include personal health information, they did involve confirmation of personal details such as address and date of birth.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff told us that the length of appointments was flexible depending on whether it was a first appointment or follow up. Patients reported that appointments were long enough to allow them to discuss treatment options and to ask any questions they had.
- We saw that written information was provided to patients to help staff explain their condition and treatment plan. The service used an internet software programme which had a range of patient information leaflets split by specialities that could be downloaded

and printed for use. We observed staff take time to explain the importance of following written advice and exercises that were provided by the physiotherapy department.

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 noted that relatives were able to attend appointments with patients and that there was opportunity for patients and relatives to ask questions about their planned care. This meant that they were involved in making shared decisions about care and treatment. Physiotherapy staff told us that they discussed and agreed treatment goals with patients, although this was not routinely documented.
- Managers told us that patients received copies of clinic letters sent between the hospital and patient's GP which provided information about their care and treatment.

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.

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

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 outpatient department 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). The local clinical commissioning group (CCG) set criteria within their contract for NHS patients' attendance at the hospital. This meant that local commissioners were involved in the planning of local services.
- The main hospital reception area, provided a manned reception desk, although there was no privacy line or sign to request patients to respect the privacy of others. The reception desk was next to the main hospital entrance and we observed queues of patients waiting to book in for appointments which obstructed the entrance to the hospital.
- In the outpatient waiting area there was adequate and appropriate seating. There were facilities for hot and cold drinks to be purchased and a range of magazines and patient information leaflets were available. Patients were called through for their outpatient appointments to clinic rooms by nursing staff.
- The physiotherapy department had a separate reception, waiting area and treatment area in a different building across the car park. This environment was small but adequate as fewer patients attended the physiotherapy department compared to outpatients.
- There was a free car park at the hospital for patient use, although some patients reported that car parking spaces could be difficult to find sometimes.
- We saw that there was clear signage in the reception area and outpatient department.
- Outpatient clinic appointments and physiotherapy appointments were available in the early evenings and on Saturdays in order to provide patients with flexibility and choice of appointment times.
- For those patients who were self-funding, information about fees was sent out with appointment letters. However, in physiotherapy there was no system to provide written information about fees; they were discussed verbally by reception staff prior to booking appointments but were not provided to patients in writing. It was not clear how transparent the fees were in physiotherapy; we were told that when patients were seen by an assistant physiotherapist they were charged the same fee as when they were seen by a registered physiotherapist. There was no evidence that this was made clear to patients.

Meeting people's individual needs

- **Staff in the service generally took account of patients' individual needs.**
- There was ramped access to the main hospital and physiotherapy buildings which took account of the needs of people with disabilities.
- Chairs suitable for patients of excess weight were available in the waiting area, although there were no

facilities for these patients within clinic rooms. The hospital had exclusion criteria for patients with a high body mass index, which would indicate obesity, hence such facilities were rarely required.

- Staff told us that there was access to interpreting services for patients whose first language was not English. This included the use of language line and face to face interpreter support. Staff told us that patients were not charged for any costs associated with interpreter support.
- Managers told us that support for people with other communication difficulties was available, such as support from services who could communicate with British sign language for deaf patients.
- There was limited understanding of meeting the needs of patients living with dementia. Staff reported having access to online dementia training but stated that completion of this was not compulsory. However, the hospital told us that there was 95% compliance with completion of the three dementia eLearning modules across all staff groups. We were told by staff that they rarely had to work with vulnerable patients such as those living with dementia or a learning disability. These patients were usually treated at the local acute trust as they were better able to treat patients with more complex needs.

Access and flow

- **People could access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.**
- There were two booking teams who processed all the referrals for outpatient clinic appointments. The bookings team for NHS patient appointments told us that following referral by their GP, patients were sent a letter which provided booking details for clinic appointments. Patients could access an online system and choose a convenient appointment date and time or they could telephone to make an appointment. They told us that they received between 1,100 and 1,300 referrals for NHS patients per month. For privately funded patients, a second bookings team managed the appointments which were all offered by telephone. The bookings teams screened all referrals for any exclusion criteria. The hospital head of clinical services (matron) supported with the screening process if clinical advice was required. Staff reported that exclusion numbers were low and that from July 2018 and September 2018 between seven and 16 referrals were excluded each month due to being outside of criteria. The main reason reported for exclusion was a body mass index of more than 40.
- We saw that after consultations, patients were given information about when to expect their next appointments. The bookings team arranged all follow up appointments for patients and booked appointments for surgery.
- In the physiotherapy department, patients who had been on the ward and needed follow up physiotherapy were given an appointment by the ward staff prior to being discharged home. Patients who had not been inpatients of the hospital were able to make appointments for physiotherapy over the telephone. A referral was required for patients funded through insurance companies, but for self-funded patients a referral was not required.
- Waiting times for appointments were minimised. Staff told us that privately funded patients were offered an outpatient appointment within a week. For NHS appointments there was a target for patients to receive treatment within 18 weeks. Referral to treatment time (RTT) data for non-admitted patient pathways in the outpatient department showed that there was between 98% and 100% compliance with the 18-week target. The average wait time from referral to treatment was 5.7 weeks. For details of the RTT data please see the surgery report.
- Time taken to offer outpatient clinic appointments for assessment was monitored by the bookings team on a patient by patient basis, to support achievement of the RTT targets. However, there was not a process for collecting and reporting on referral to assessment wait times. Most patients we spoke with told us that they had been offered an appointment within a couple of weeks of referral. Physiotherapy wait time for appointments data was not collected but staff told us that there was a minimal wait for new appointments.
- We spoke with patients and relatives in the outpatient waiting area and they told us that clinics generally ran to time. Most patients had been seen within 15 minutes of their appointment time. Staff told us that if clinics were running more than 20 minutes late, reception staff would be informed and would advise patients as they

booked in that clinics were running late and apologise for this. However, one patient we spoke with had been waiting for 30 minutes and told us that they had not been informed that the clinic was running late.

- Clinic appointment slots were planned up to a year in advance around consultant availability. Staff in the bookings team told us that there was an expectation that consultants did not cancel clinics within six weeks of the planned clinic date. We were told that sometimes cancellation was unavoidable due to sickness. A log was kept of reasons for cancelled clinics, notice period given for cancellation and numbers of patients cancelled. We saw that between 20 and 81 clinic appointments had been cancelled each month from August 2018 to October 2018. The main reasons given for cancelled clinics were consultant unavailability due to sickness, changes in on-call rotas at the acute hospital where they worked, and study day attendance. Staff told us that patients were rebooked for any cancelled appointments as soon as possible. One patient we spoke with told us that her follow up appointment arranged for after her surgery had been cancelled four times.
- There was a system to manage the rates of patients who did not attend (DNAs) for appointments. Staff told us that a monthly list of DNA numbers was sent to the quality team who monitored this and reported on it at governance meetings. Data provided by the hospital showed that from August 2018 to October 2018, there had been a total of 520 DNAs at clinic appointments. We were told that if patients DNA appointments, they would be sent a letter asking them to contact the service to make another appointment. If patients did not respond to this letter within two weeks then they would be discharged. Managers told us that patients were not currently charged for missed appointments.

Learning from complaints and concerns

- **Staff in the service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- We saw that complaints leaflets, providing patients with information on how to complain, were available in all departments.
- Staff told us that they tried to manage complaints at a local level where possible and address concerns at source as soon as they were raised. The hospital encouraged heads of departments to take ownership of complaints management and include staff involved in the investigation. Managers were supported with investigations by the head of clinical services and the quality improvement team. Responsibility for sign off for all complaints sat with the hospital director.
- The hospital reported 51 complaints during the reporting period from August 2017 to July 2018. The top three themes identified were administrative communication issues, clinical care by consultants, and consultant attitude and behaviour. We saw that three of the complaints logged related to outpatients; two of these were about consultant attitudes during consultation and one about administrative errors. All of these complaints had been actioned and letters had been sent to patients which included apologies.
- The hospital told us that individual services used feedback from concerns raised to learn lessons and make improvements. In addition, complaints were discussed across the hospital at the quarterly shared learning forum events. Complaint issues and themes were discussed at clinical governance meetings attended by the head of clinical services and heads of departments. Complaints and actions were discussed at the medical advisory committee with consultants to share learning and promote reflection.
- 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 requires improvement.

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

Leadership

- **The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.**
- There were named and experienced managers in the outpatients and physiotherapy departments. Each lead

was passionate about the service they led and worked well with the team of staff in their department. There was a strong sense of team working in each department and all staff worked well together, whatever their role.
- Staff we spoke with told us that they felt well supported by their department managers. They told us that they were approachable and available to help, regularly working clinical shifts within the departments.
- During our inspection, staff reported to us that managers in the executive team were visible leaders and regularly visited all departments to spend time talking to staff. They told us that the hospital director and head of clinical services were approachable and would listen to concerns and ideas. Staff reported that the clinical lead held drop in sessions when staff could meet with them to share ideas or discuss concerns. Communication in the form of emails and newsletters was sent out by the executive team to update staff on developments within the hospital and the wider Ramsay healthcare UK group.
- Leadership development programmes were available to staff through the Ramsay academy and the heads of department we spoke with had completed leadership training since being in post.
- See information under this sub-heading in the Surgery Report section

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with some involvement from staff.**
- One manager told us that the vision and strategy had been developed with staff involvement through the delivery of workshops which staff were encouraged to participate in. However, other staff were unaware there was an opportunity to be involved. They told us the values had been developed by head office. The staff members we spoke with knew there was a set of values that were based on the six C's and that the focus was patient centred care. The six C's, refers to the NHS values of care, compassion, courage, communication, commitment and competence.
- 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.**
- Staff we spoke with all told us that they felt supported, respected and valued by both managers and other staff. They described having positive working relationships with peers and managers.
- Several staff told us they enjoyed their job and felt a sense of pride in their work stating they had worked happily at the hospital for many years.
- There was a culture of openness and honesty; staff told us they felt comfortable to raise concerns with managers and confident that they would be listened to and taken seriously.
- There were mechanisms in place for staff development which included a system for setting objectives in annual appraisals. Additional learning opportunities were available to develop staff knowledge and skills, which most staff told us they had been able to access. However, reception staff and health care assistants we spoke with did not report being offered additional training opportunities.
- Staff in outpatients and physiotherapy worked together collaboratively in their teams to share responsibility: tasks were delegated to individuals. In outpatients, we heard how each clinic room was allocated a named nurse who then had overall responsibility for that room each day. Additionally, there was a system of a named nurse in outpatients on a daily rota basis which was designed to relieve the burden on the manager and promote a sense of shared ownership.
- See information under this sub-heading in the Surgery Report section.

Governance

- **Leaders 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. There were clear reporting structures within each department with a named lead having individual responsibility for that department. All department leads told us they reported directly to the head of clinical services.

Good

Outpatients

- There were regular meetings attended by the heads of department and the head of clinical services. Minutes of these meetings showed that these meetings happened monthly and followed a standing agenda which reviewed finance, complaints, audit results and monthly performance data. There was a list of attendance and an action log to monitor progress against identified actions.
- There were bimonthly meetings between the heads of department, executive team and the hospital director which included clinical governance meetings, infection prevention and control meetings and health and safety meetings. Feedback from these meetings was provided to staff at team meetings held for each service.
- Minutes of team meetings showed that they happened at different frequencies depending on the department, and were chaired by the department manager. They followed standing agendas which included HR issues, finance, governance and feedback from senior management meetings.
- See information under this sub-heading in the Surgery Report section.

Managing risks, issues and performance

- **Leaders had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the local risk registers held in each department documented potential risks which were long standing and were already mitigated. These had not been regularly reviewed and should have been removed from the register. There was not a consistent approach to overseeing compliance with requirements such as training and equipment maintenance.**
- We saw that 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 if they were scored as moderate or high risks. We saw a copy of the hospital risk register and noted that each risk identified had a list of associated mitigating actions in order to reduce the risk. In addition, a responsible person and review frequency were documented.
- We spoke to department leads about risks within their service and found that risks they identified were not always current risks. For example, in outpatients, one risk identified was the use of the plaster saw due to the potential risk of patient injury. There was a standard operating procedure in use for the plaster saw and there had been no recent incidents of injury to patients. Neither was there any fault with the equipment nor lack of staff knowledge and training in its use. This risk had been identified as a low risk score on the local risk register for over a year, without any change to the risk score. There were also other risks identified in outpatients and physiotherapy that were no longer current risks to the service. These included the use of the treadmill for exercise testing which was identified as a risk due to the chance of a patient becoming unwell during the test. This was a known possible adverse event of a treadmill test which was explained to patients and mitigated by close monitoring of patients. Also, in physiotherapy we were told that acupuncture always sat on the local risk register due to the possibility of side effects as it was an invasive procedure. These were discussed with patients during the consent process and mitigated by following a standard operating procedure which identified exclusion criteria for any patients at risk. Therefore, we were not assured that staff fully understood the risk assessment process as not all the identified risks were current risks to the service.
- One manager described systems and processes which supported monitoring of performance and issues. They told us they had access to an online system to monitor things such as training compliance and equipment maintenance. However, another manager did not appear to be aware of these systems and told us they relied on ad hoc processes to access this information. They told us that they were sent this information from the quality team every few weeks. We were not assured that all managers used systems and processes which gave them oversight of performance and compliance issues.
- 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.
- There was a systematic audit of operational processes to monitor whether standards within policies were being met. For example, standards for record keeping, completion of appraisals and training, observations of

clinical care, environmental safety and infection control practises. However, there was no programme of systematic clinical audits within the outpatient and physiotherapy departments.
- See information under this sub-heading in the Surgery Report section.

Managing information

- **Leaders collected, analysed, managed and used information well to support all the service activities, using secure electronic systems with security safeguards.**
- Managers told us that there were electronic systems to manage some data and that this was monitored by the quality improvement team. This included data for training compliance and audits.
- One manager described having access to electronic systems containing quality data, however, one manager relied on information being sent out by email. This meant that not all staff had access to information on quality in a timely way.
- The physiotherapy manager explained 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

- **Staff in the service engaged well with patients and staff to plan and manage appropriate services effectively.**
- Patient views on their experience of the care they had received were gathered through a variety of methods. NHS patients were encouraged to complete the friends and family test (FFT). We saw hospital wide data for FFT results which showed that from February 2018 to July 2018, there was an overall satisfaction score of 99% from an average response rate of 26.5%. Results were shared and reviewed at clinical governance meetings and at meetings with relevant commissioning groups. We saw that there were posters encouraging patients to complete Ramsay healthcare UK feedback questionnaires; these could be completed in leaflet form or online. We noted that there were comment card boxes on the main reception for patients to leave feedback. Patients' experience of classes delivered in the physiotherapy department was also captured and reported to the quality team.
- We saw that the hospital took patient comments seriously and used feedback to improve services. For example, the hospital told us that a review of the telephone system had been undertaken to ensure patient calls were directed to the most appropriate person first time.
- There was a review underway of the outpatients waiting area in response to feedback received from patients. The review sought to reduce delays and improve communication within the department.
- Staff were engaged in service development. They told us that 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.
- We were told that the physiotherapy managers met corporately across the Ramsay healthcare UK group clusters in order to review working processes, issues of concern, and share learning. This demonstrated effective partnership working across the hospital group.
- See information under this sub-heading in the Surgery Report section.

Learning, continuous improvement and innovation

- **Staff in the service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.**
- There was a culture of improvement in the outpatient and physiotherapy services. Managers told us about ongoing plans to improve their services. In outpatients, the manager had allocated named staff to clinic rooms in order improve the efficiency of service delivery. The named nurse had responsibility for ensuring the room was clean and fully stocked and fit for purpose on a daily basis.
- In physiotherapy, the manager told us that ideas to develop the service had been discussed and agreed with the executive team. They planned to develop specialist rehabilitation exercise classes for specific conditions such as cancer and diabetes. Additionally, there was senior management support for development of sports injury rehabilitation services.

Good

Outpatients

- See information under this sub-heading in the Surgery Report section.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

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 service provided all staff with training appropriate to their needs. This included a series of face to face sessions and e-learning training packages. Data provided showed that mandatory training figures in the imaging department was 100% for ten out of 13 face to face training topics. This included fire safety, manual handling, infection control and information security. Three topics were below 100% this included basic life support (90%), speak up for safety (85%) and safeguarding training (56%).
- Data showed that imaging staff were 96% compliant with e-learning training modules. Topics for e-learning training included information security, drug calculation assessments, health and safety and safeguarding adults and children.
- The service provided training on site through staff members who had received additional training, or by external or corporate trainers.
- Heads of department had access to an electronic training record, which detailed all of their staffs training compliance. This was used to inform governance and performance meetings.

Safeguarding

- **Staff understood how to protect patients from abuse and knew how to recognise and report abuse.**
- Staff working within the imaging department were aware of safeguarding but had limited experience of managing concerns due to the brief contact with patients and their relatives. Staff were aware of escalation processes. 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.
- Service data showed that although the face to face safeguarding training had been completed by 56% of staff, e-learning safeguarding training had been completed by over 91% of staff. Full details of training compliance can be found within the surgery report.
- Safeguarding adults and children policies were in-date and were accessible to staff through the hospital's intranet. They included clear guidance on how to manage suspected abuse and radicalisation, and details of who to contact for further support and guidance
- Staff could name the safeguarding leads for the hospital for both adults and children's safeguarding.

Cleanliness, infection control and hygiene

- **The service controlled infection risks well. Staff were aware of the need to maintain a clean environment and kept equipment and the premises**

clean. They used control measures to prevent the spread of infection. All diagnostic areas were visibly clean and there was no evidence of high level dust.

- Staff told us that they ensured that all equipment was cleaned after use to ensure it was ready for the next patient.
- Hand gel dispensers were located outside treatment rooms and in waiting areas with visible signage to encourage staff and visitors to use them.
- All areas were visibly clean. Domestic cleaning was completed by the hospital housekeeping staff and we were told that they prioritised high risk areas. For example, inpatient and treatment areas were prioritised over office areas. Departmental staff were happy with the level of service they received.
- We did not see staff wearing personal protective equipment during our inspection, however, there were no occurrences whereby patients needed to be assisted to complete any tasks. We saw that hand sanitiser was available and was used when entering or leaving the department.
- Staff were aware that there was an infection control lead for the hospital and knew to contact them for any advice or guidance.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- Access to the imaging department was through the hospital's main entrance, which had ramped access. All diagnostic imaging services were delivered on the ground floor of the building.
- The imaging department had recently been reconfigured to include a magnetic resonance imager (MRI) scanner which had opened in early October 2018. The MRI provision had previously been provided by an external company as a mobile scanner. In addition to the MRI suite, the department consisted of one x-ray room which was used for general x-rays and fluoroscopy investigations and an ultrasound scanning room. The department was located on the ground floor and shared a waiting area with the outpatient department.
- Patients attending the department as an outpatient reported initially to the main reception area where they were asked to wait in the waiting area. A member of the diagnostic team would then call the patient into the department for their investigation. Inpatients were called to the department when a suitable time slot became available.
- The MRI scanner was in a separate corridor which was accessed by a pass card. This meant that only persons authorised or accompanied by a member of staff could access the department.
- Staff told us that there was a formal capital rolling replacement programme for equipment. With the x-ray equipment planned to be replaced in 2019. We were told that equipment was under a service level agreement for maintenance with an external provider.
- We saw evidence that quality assurance testing was completed at regular intervals in line with the Institute of Physics and Medical Engineering (IPEM). There was a paper record of all testing which had been updated in the four months prior to inspection. The annual report was completed by an external reviewer, when all equipment was tested to ensure it was safe to use. The service also maintained an electronic record of monthly quality assurance testing.
- The service had introduced a MRI safe resuscitation trolley into the MRI waiting room. The trolley was well equipped and maintained. Staff checked the equipment on the days which the service was open. Staff told us that they were being supported by the resuscitation training officer to ensure that they were familiar with the equipment and maintain stock. Local records showed that equipment was checked, and we saw that the trolley was clean.
- The service also provided an emergency grab bag which could be used by visiting scanning services.
- We reviewed stock of clinical treatment items in the clinic rooms and store rooms and found that all the items we checked were in sealed packaging and within their expiry date.
- We saw that there were sharps bins in each clinic room and these were dated and not overfilled beyond the fill line.
- Patient waiting areas did not always facilitate privacy for patients however, due to the number of patients being seen, the department would complete one investigation at a time. Patients were called to the imaging room and had their investigation immediately which promoted privacy and dignity.
- 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. The MRI scanning room had a retractable barrier which was placed in front of the doors when the scanner was in use. This acted as a deterrent for staff or patients to walk into the scanning room when it was in use. This was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance for access.

- Local rules as required under IRR17, were not displayed on imaging room doors. All areas that utilise medical radiation in hospitals are required to have written and displayed local rules which set out a framework of work instructions for staff. Local rules refer to the risks associated with each modality and steps taken by staff to ensure that procedures are completed safely. These should be displayed on the door to each modality area.
- We saw that lead aprons and neck shields were used, and routinely checked to ensure they were not damaged. Staff also wore radiation exposure devices which were analysed to ensure that staff were not over exposed. We were told that the head of department was looking at alternative methods of capturing consultant exposure. This was because the consultants worked across other sites and therefore data collection was not always appropriate to this service.
- The service lead maintained a record of staff who could request investigations. This was updated annually.

Assessing and responding to patient risk

- 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 registered medical officer (RMO). Therefore, staff did not routinely assess risk, other than that posed by the investigation itself.
- Imaging staff were aware of the need to risk assess patients prior to the requested 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.
- Investigations were requested using a paper referral system, which was signed by the consultant, and detailed the patient's demographics and details of the investigation requested. This referral card was used by imaging staff to confirm the patient's identity when attending for the investigation.
- Referrals were reviewed by imaging staff to ensure that the correct procedure was being requested, and 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. Staff told us that they would refer to the referring consultant if they had any queries or concerns regarding the requested procedure.
- We saw that 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 on arrival to the department. The service used a "pause and check" system for radiology investigations. This was based on the World Health Organisation (WHO) surgical safety checklist, which enables the identification of any risks, for example, allergies, antibiotic prophylaxis and site marking to be reviewed prior to the investigation.
- There was a robust process for the assessment of patients who may be pregnant. We saw a checklist which was used to assess any potentially pregnant patient prior to the investigation being completed.
- Patients attending the MRI department were required to complete and extensive checklist prior to the investigation. This was to identify any risks associated with metal components and the potential consequential harm. All visitors were also asked to complete the checklist, prior to admittance into the department. Anyone who was identified as being at risk, were not permitted to enter the department.
- Staff checked that patients, who required a contrast media, were not allergic to any substances prior to administering the medicine. We were told that all contrast media were administered by the consultant responsible for the investigation.
- There was a designated radiation protection advisor who was accessible and responsive to needs. All staff wore radiation badges to monitor any occupational doses. The assessment and record keeping of radiation doses are recommended under Ionising Radiations Regulations 2017.
- Following completion of the investigations, the image was reported on by either a radiologist or the referring clinician. X-rays, were sent to the referring consultant for review, ultrasounds were completed by a consultant and MRI scans were reported on by the radiologist. The service had designated reporting staff each day. This meant that there was not a delay in the implementation of treatment following the investigation.

Good

Diagnostic imaging

Radiation Protection

- The head of department was the radiation protection supervisor (RPS). The RPS role is required under the ionising radiation regulations 2017providing and supervisory role in the radiation protection aspects of the work. There is also a requirement for the RPS to be aware of what actions to take in an emergency. The Ionising Radiations Regulations 2017 (IRR17) guidance states that the number of RPS should be determined by the number of different locations, the range and complexity of radiation work undertaken, and factors such as shift work, and any planned/ unplanned staff absence.
- The service provided us with evidence that there was regular engagement with the medical physics services. There were regular meetings between the medical physics service and the radiation protection advisor. Radiation protection services were supplied by an external radiological protection service. The company were responsible for the provision of a radiation protection advisor, medical physics expert, radiation waste advisor and magnetic safety advisor.
- We saw that staff radiation exposure was monitored and regularly audited. We saw the audit results for October 2018, which showed that no member of staff had been exposed to radiation. In addition to staff monitoring, the service maintained dose audits for the x-ray department. These were saved against investigation and allowed comparisons to be made to previous data captured.
- We saw that policies were in place to ensure that practice followed the most recent guidance and regulation. The head of department had updated files in line with the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R procedures and standard operating procedures as required under the Regulations. The Health and Safety Executive (HSE) regulate the Ionising Radiations Regulations 2017 (IRR17).
- We saw that lead aprons and screens were tested annually to ensure that they were fit for purpose.
- The service's last radiation protection advisor (RPA) audit was carried out in June 2018. The report contained sections on equipment, staff dose, risk assessments, local rules, personal protective equipment, training, incidents, environment, IR(ME)R issues and patient dose. There were no identified issues and no actions recorded.
- The service lead attended a radiation protection committee meeting which was held six monthly. We saw that the meetings followed a set agenda and reviewed aspects such as training, incidents and safety. Meetings were completed across Ramsay healthcare to ensure that peers were supported.

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 Imaging department was staffed by ten members of staff including the head of department, radiographers and health care assistants. There was a small number of vacancies following the recent expansion of services. This meant that the MRI department was currently open three days per week, 8am to 8pm. There was a plan for the department to open a fourth day, however, additional staffing was required to enable this.
- See information under this sub-heading in the Surgery Report section.

Medical staffing

- We were told that there was a small group of radiologists who worked 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.

Records

- Staff kept appropriate records of patients' care and treatment. Images were archived using an electronic database and were password protected to prevent unauthorised access. Images could be shared with external systems if necessary. This was particularly useful for when a specialist opinion was required.
- We saw that details of all investigations and their findings were recorded electronically on the database. Staff could access previous images if necessary to ensure multiple images were not being completed.

Good

Diagnostic imaging

- Throughout all department, care was taken to ensure that computer screens were not accessible or in view of unauthorised persons. Computers were locked when not in use.

Medicines

- For our detailed findings on medicines please see the Safe section in the Surgery report.
- The imaging department used a small number of medicines for investigations. These were largely contrast media. We saw that these were stored in locked cupboards within the x-ray room. We were told that when medicines were taken to the visiting mobile CT scanner, staff checked them out and in when they were brought back to the department.
- Consultants were responsible for the prescribing and administering of all medicines for patients attending the service. This meant that no imaging staff were responsible for the administration of medicines.

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.**
- There was a Ramsay healthcare UK group policy for incident reporting, which was in date. The policy identified individual's responsibilities for reporting and investigating incidents. Staff we spoke with could describe when they would report an incident and the process used. Staff had access to the electronic reporting system.
- Hospital data showed the numbers of reported incidents across the imaging department. From April to June 2018, there were 16 clinical incidents reported and one non- clinical incident reported for the Outpatients and Imaging departments. For July to September 2018, there were ten clinical and two non-clinical incidents reported for Outpatient and Imaging departments. The hospital did not provide a breakdown of incidents according to department, however, they did identify that there was one radiology incident from April to June 2018 and two from July to September 2018. There were no IR(ME)R reportable incidents.
- Service data showed that there were no never events or serious incidents reported in the outpatient department during the reporting period.
- Staff received feedback from incidents reported at shared learning forum events which all staff were invited to attend. Managers also fed back to their teams locally at team meetings.

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. Managers checked to make sure staff followed guidance.**
- We saw that the service had appropriate policies, procedures and protocols in place to manage patients safely. During this inspection, we saw that the service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Care and treatment was delivered in line with legislation, standards and evidence-based guidance.
- Staff worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and guidelines from the National Institute of Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. This included all specialities within the diagnostics.
- The service had a defined audit schedule in place and audits were completed regularly. These covered topics such as record keeping, hand hygiene and environment.
- There were policies to ensure that patients were not discriminated against. Staff were aware of hospital policies and gave examples of how they followed guidance when completing care and treatment. Staff told us that they would escalate any concerns and seek further guidance if necessary.

Good

Diagnostic imaging

Nutrition and hydration

- Patients attending the imaging areas were advised whether they were permitted to eat or drink prior to their appointments, depending on the investigation required.
- There was water provided in the main waiting area should patients require a drink whilst waiting for their appointment.
- See information under this sub-heading in the Surgery Report section.

Pain relief

- Patients were not provided with analgesia when attending the imaging department. See information under this sub-heading in the Surgery Report section.

Patient outcomes

- Patient outcomes were not measured by the imaging department. 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 head of department monitored staff 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. Data showed that for the current appraisal year, January 2018 to December 2018, 82% of registered nurses and 100% of health care assistants had received an appraisal. This data was for staff working in the outpatient and diagnostic imaging services.
- 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.
- Imaging staff had a number of competencies to complete according to the location worked. For example, a member of staff completing imaging in theatres was expected to be be competent in tasks specific to that clinical area, such as manoeuvring the monitors and c-arm (imaging equipment). Staff were not permitted to complete images without being either supervised, or deemed competent.
- During inspection, we were told that all radiographers had in date health care professional registration (HCPC). This is 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.

Multidisciplinary working

- For detailed findings on multidisciplinary working please see the Effective section of the Surgery Report.
- We saw that the imaging team worked closely with the visiting consultants. Multidisciplinary team meetings occurred at the local acute hospital trust and were not minuted by the service.
- Staff told us that they would meet with their peers working across the Ramsay hospital group. They described quarterly meetings, where heads of department would meet to share ideas and work together on consistent approaches to the delivery of care across the Ramsay group.

Seven-day services

- The imaging department provided a six-day service for x-rays from 8am to 8pm Monday to Fridays and 8am to 4pm on Saturdays. Out of hours there was an on-call service. Staff confirmed that they seldom needed to attend for an urgent x-ray.
- The MRI department was open 8am to 8pm three days per week, with plans to open a fourth day when able.
- The ultrasound department was open as per consultant clinics, and as requested.

Health promotion

- See information under this sub-heading in the Surgery Report section.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.**

Good

Diagnostic imaging

- 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 and non-contrast MRI scans. Patients attending for invasive procedures were consented by the responsible consultant. This could be written consent, depending on the investigation completed.
- The consultant responsible for the procedure would obtain consent from the patient prior to an invasive investigation following a detailed account of the investigation process. We did not see any of these procedures during the inspection, and therefore are unable to confirm practice completed.
- 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 staff caring for patients with compassion and understanding. We saw that all staff introduced themselves to patients, giving details of their name and ensuring that they knew what they were attending the department for.
- Patients were called from the waiting room and staff used this time to put patients at ease, talking openly and comfortably. Staff were observed taking time when possible to interact with patients and their relatives. We observed staff taking time to speak with patients in a respectful and considerate way.

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 were able to communicate with patients undergoing MRI investigations and we saw they regularly checked that patients were comfortable and not distressed during procedures. We saw that staff regularly updated patients on the time left for their investigation and provided distractions for patients who felt claustrophobic. The MRI scanner was designed with a wider opening than average equipment which meant that patients were not as enclosed.

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 told us that they were involved with decisions about their care and treatment. Staff could give advice regarding investigation reporting and explained that they would need to see the referring consultant for further information.

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 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. MRI staff told us that they had received an increase in referrals following their recent new build.

Good

Diagnostic imaging

- The local clinical commissioning group (CCG) set criteria within their contract for NHS patients' attendance at the hospital. This meant that local commissioners were involved in the planning of local services.
- Radiographers worked a shift system to ensure that there was a member of staff in the department during core business hours (8am to 8pm Monday to Friday and 8am to 4pm Saturdays). There was an on-call radiographer out of hours and at weekends.
- Where possible, the service provided imaging appointments in conjunction with the patient's outpatient consultant appointment. This enabled images to be reviewed by the consultant whilst the patient was at the hospital. This reduced attendances at the hospital and enabled treatment to be adjusted according to the patient's condition. For example, patients attending for a review of an orthopaedic procedure had their x-ray and consultant appointment at the same time preventing patients from attending the hospital on two separate occasions.
- See information under this sub-heading in the Surgery Report section.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Once patients had registered as attending for their appointment, a member of staff accompanied them from the general waiting area to the investigation room. We saw that staff ensured the patients knew where they were going to exit the department and hospital.
- The recent reconfiguration had meant that there was no longer a changing room for the x-ray or ultrasound rooms, however staff told us that if patients were required to wear a gown, they would leave the room to give them some privacy whilst they changed. Patients attending for an MRI investigation were accompanied to one of two changing rooms. Patients could sit in the changing room until they were called into the scanning room. Patients were seen one at a time, which prevented waiting for appointments in gowns and promoted dignity.
- Staff had access to translator services for non-English speaking patients and British sign language for the hard of hearing. Staff told us that they could book translators to accompany patients to the department in advance of their appointments. This was dependent on the knowledge that the patient required assistance. However, staff could access a telephone service on the day if necessary. There was also a hearing loop available at main reception.
- Staff confirmed that they were usually unaware if the patient attending the clinic had mental health needs or other additional needs such as a learning disability. 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 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.
- Waiting areas 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 room from the main waiting area. We saw staff assisting patients with mobility aids to walk to the appropriate modality area. There was also a MRI safe wheelchair that was used for patients with reduced mobility attending for MRI investigations.
- There were patient toilets located in both the general x-ray and MRI departments. These were suitable for use of patients who had reduced mobility and required mobility aids or wheelchairs.
- Patients attending the imaging department from the inpatient ward were required to be brought to the area by wheelchair. We saw that porters or nursing staff accompanied patients to prevent any delays in returning to the ward.

Access and flow

- **People could access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.**
- Patients attending the department as an outpatient reported initially to the main reception area where they were asked to wait in the waiting area. A member of the diagnostic team would then call the patient into the department for their investigation. Inpatients were called to the department when a suitable time slot became available.
- We were told that there was a group of radiologists with varying specialities who reported on MRI scans. The team worked specific days which ensured that all scans were reported on within a week of the investigation

being completed. If a review was required by a different specialist, the image could be forwarded to the appropriate specialist for review. Staff confirmed that most scans were reviewed within 72 hours.
- X-rays and ultrasound reporting was completed by the referring consultants. All ultrasound investigations were completed by a consultant. This meant that most of reporting was completed at the time of the investigation (hot reporting).
- Imaging staff told us that the 'did not attend' (DNAs) figures were negligible with two DNAs for the July to September 2018. The service monitored the number of DNAs on a quarterly basis. Patients who did not attend were referred back to the requesting doctor to enable a follow up appointment.
- The waiting time for imaging services was less than five weeks. The service provided us with data relating to their waiting list. There were 51 patients referred for treatment as of the 11 October 2018. The majority of which had been waiting for less than one week (31), 11 had been waiting between two and three weeks and the remaining eight had been waiting for four to five weeks. RTT data was not broken into modality.

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.**
- Staff were aware of the local procedures for managing concerns and complaints. Where possible staff managed concerns locally to prevent escalation. Staff were aware of the policy for the management of complaints and were aware that they could access this on the intranet. In the first instance, staff would speak to the head of department or head of clinical services (matron) if concerns arose.
- We reviewed the hospital complaints' log for May to October 2018 and found that none referred to the diagnostic imaging 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 requires improvement. 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 with a head of department (HoD) who was also the supervisor. The HoD worked clinically as part of the team in addition to completing management tasks and duties. Staff spoke positively about the leadership of the team and hospital.
- We were told that senior leaders frequently visited the department and were approachable and would listen to any concerns raised.
- See information under this sub-heading in the Surgery Report section.

Vision and strategy

- **The hospital 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.**
- 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 MRI 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.**

- All staff were enthusiastic about their jobs and the team in which they worked. Staff told us that it was a "great place to work" and one staff member told us that they had returned to work here after leaving several months previously.
- Staff felt supported in their work and there were opportunities to develop their skills and competencies, which was encouraged by senior staff. Staff felt listened to and said they worked well as a team.
- We saw that there were various methods of communication across the team, including a newsletter.
- See information under this sub-heading in the Surgery Report section.

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 HoD reported directly to the senior leadership team with clear lines of escalation in place.
- Bi-monthly meetings had been introduced with the new leadership and minutes showed a standardised format was used for reporting on performance by modality, recruitment, service plans and finance. Minutes were descriptive and were circulated to the wider team for information. These meetings had only been in place for a few months and were developing as staff became more familiar with the process.
- In addition to service performance reviews, staff could attend speciality meetings for link roles. For example, staff with an interest in infection control could attend the infection prevention and control meetings. These gave staff the opportunity to share learning and determine any actions that should take place in response to audit results, complaints or new guidance.
- 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.**
- There was a local risk register which was maintained by the HoD. Risks identified were recorded on a standardised template which scored risks 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. We saw that the risk register was reviewed regularly, and any actions taken to mitigate risks recorded.
- The risk register was discussed as part of the service performance review meeting.
- See information under this sub-heading in the Surgery Report section.

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.
- 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 service engaged well with staff and collaborated with partner organisations effectively to ensure that patient safety was maintained.
- Staff engagement had improved over recent months, particularly with changes to senior leadership and the completion of reconfiguration of services.
- Staff surveys were completed annually, all staff reported that they enjoyed working at Woodland Hospital and were proud of the work completed.
- Due to patients attending the department for a short period of time, the service did not collect feedback from patients. However, feedback about patients' experiences at the hospital were captured. 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.**
- See information under this sub-heading in the Surgery Report section.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The outpatient service must ensure that consent for minor procedures is always gained and recorded in line with legislation and corporate policy.

Action the provider SHOULD take to improve

- Services should ensure that patient risks and treatments are accurately recorded, detailed, signed and dated in line with local policy.
- Services should ensure that staff comply fully with the infection prevention and control policy.
- Services should ensure that all managers have oversight of equipment records with regards to replacement and maintenance schedules.
- Services should ensure that post-operative pain management is clearly recorded in patient notes.
- Outpatient services should identify areas where patient outcomes could be captured to evidence the effectiveness of care and treatment.
- The Physiotherapy service should be transparent with patients about transferring treatment sessions to therapy assistants and ensure patients are clear that some of the therapy sessions they receive are not delivered by registered staff.
- Service leads should ensure that complaints files reflect all actions taken by the team, such as telephone conversations, to resolve concerns raised.
- Managers should ensure that all appropriate risks identified are accurately reflected in local and hospital wide risk registers and that risk registers are updated regularly to reflect active risks and actions
- Managers should ensure that performance data is accessible to all staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person. Policies and procedures for obtaining consent to care and treatment must reflect current legislation and guidance, and staff must follow them always. The outpatient service did not always ensure that consent for minor procedures was gained and recorded in line with legislation and corporate policy.