Ashtead Hospital

Quality Report

The Warren
Ashtead
Surrey
KT21 2SB
Tel: 01372 221444
Website: www.ashteadhospital.co.uk

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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Ashtead Hospital is operated by Ramsay Health Care UK Operations Ltd. The hospital has 29 ensuite patient rooms, a two bedded extended recovery area and 13 ambulatory care pods, of which four have ensuite WCs. Facilities include three laminar flow operating theatres (a system that circulates filtered air to reduce the risk of airborne contamination), an in-house Theatre Sterile Services Unit alongside the theatre suite, used to clean and sterilise all the hospital's surgical instruments and their sister hospital's instruments, and a five bedded recovery area. There is a dedicated Joint Advisory Group (JAG) accredited endoscopy unit with its own recovery area, 13 consulting rooms within the outpatient unit and seven designated treatment rooms within the physiotherapy department. The diagnostic imaging department includes X-ray, MRI and CT.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected surgery, outpatients and services for children and young people. Medical care services are reported under the surgery section. Services for children and young people were limited to outpatients and represented 3% of the hospital's total activity, with most aged 0 – 15 and a small proportion aged 16-17.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 12 – 14 December 2016.

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

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

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

Services we rate

We rated this hospital as good overall. Although some elements of the children and young people's service required improvement, the overall standard of service provided throughout the hospital was largely good. Since the children and young people's service represented only 3% of the hospital's total activity, we have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and is reflective of a proportionate judgment.

We found good practice in relation to surgery:

- Openness and transparency about safety was encouraged. Staff understood their responsibilities in relation to incident reporting. Staffing levels and skill mix were planned and reviewed to keep people safe at all times.
- Decision making about the care and treatment of a patient was clearly documented and record keeping was comprehensive.Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation and staff adhered to infection control policies and protocols.
- There was an effective system in place to ensure the monitoring, storage and availability of medicines.

We found good practice in relation to outpatient care:

Summary of findings

- There were clearly defined systems, processes and standard operating procedures to provide safe care and respond in emergencies. Staff had a good understanding of how and when to report incidents and reflected that they understood the duty of candour and knew when to apply it.
- Staff worked collaboratively to share best practices and meet the patients' needs. We saw multi-disciplinary working across departments and with other Ramsay Hospitals.
- The care provided to patients was consistently compassionate, with staff listening to patients' concerns and responding in a way that reflected they understood and acknowledged the patient's medical, personal and social needs.
- Services were planned and delivered to meet local needs with appointments available at a range of times to accommodate patient choice.

We found areas of practice that require improvement in services for children and young people:

- A new system of record keeping for children and young people meant that insufficient information was kept on file to provide a full record of the patient's treatment.
- There was a lack of audits relating to children and young people attending the service which meant there was no effective way of monitoring patient clinical outcomes other than patient feedback.

We found areas of practice that required improvement in outpatients and diagnostic imaging:

- Patient records were not always complete and sometimes excluded consultant's names, patient condition and treatment. In some cases, the consultant kept original copies of patient records.

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 also issued the provider with three requirement notices that affected Outpatients and the Children and Young people's services. Details are at the end of the report.

Professor Edward Baker
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 safe, effective, caring, responsive and well-led.
Services for children and young people	Requires improvement 	Children and young people's services were a small proportion of hospital activity. The main service provided for children was outpatients. Where arrangements were the same, we have reported findings in the outpatients section. We rated this service as requires improvement because safe, effective, and leadership required improvement, although the service was rated as good for responsive. There was insufficient evidence to rate this service for caring.
Outpatients and diagnostic imaging	Good 	Outpatients and diagnostic imaging were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was caring and responsive, although it required improvement for safe.

Summary of findings

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Ashtead Hospital

Services we looked at:
Surgery;Services for children and young people;Outpatients and diagnostic imaging

Summary of this inspection

Background to Ashtead Hospital

Ashtead Hospital is operated by Ramsay Health Care UK Operations Ltd. The hospital opened in 1984. It is a private hospital in Ashtead, Surrey. The hospital primarily serves the communities of Surrey. It also accepts patient referrals from outside this area.

The hospital carries out a variety of different procedures including, general, minimal access (surgery completed with one or more small incisions instead of a large incision), gynaecology, urology, orthopaedic ,dental, ear nose and throat and endoscopy (examination of the inside of the body by using a lighted, flexible instrument called an endoscope) procedures.

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

The registered manager has been in post since July 2016.

Our inspection team

The team that inspected the service comprised four CQC inspectors and specialist advisors with expertise in theatre nursing, medical care nursing, radiography, paediatric care and safeguarding and senior nurse management. The inspection team was overseen by Elizabeth Kershaw, Inspection Manager.

Information about Ashtead Hospital

The hospital has one inpatient ward and an ambulatory care unit and 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 all clinical areas. We spoke with 30 staff including medical staff; registered nurses, health care assistants, allied health professionals, reception staff, operating department practitioners and senior managers. We spoke with 16 patients and one relative. We also received two 'tell us about your care' comment cards from patients. During our inspection, we reviewed 28 sets of patient records and a variety of unit data such as meeting minutes, policies and performance figures.

Between July 2015 and June 2016 there were 6,766 visits to theatre, 5,471 day case attendances and 1,690 inpatient attendances. Of these 57% were NHS funded and 43% were other funded. Seventeen percent of all NHS funded patients and 33% of all other funded patients stayed overnight at the hospital during the same reporting period.

The most common procedure undertaken in this period was diagnostic gastroscopy (examination of the upper digestive tract). Diagnostic gastroscopy accounted for 711, or just over 10% of all procedures. Diagnostic colonoscopy was the second most commonly performed procedure and accounted for 552, or 8% of all procedures.

Eleven of the inpatient beds were allocated for medical patients. Data supplied to us showed that between July 2015 and June 2016, 396 medical patients were treated at the hospital for a variety of conditions including: chest infections, urinary infections, respiratory conditions and dehydration in the elderly. The provider stated that they do not keep specific data on each individual condition treated.

The outpatients department had 14 consulting rooms (including one ear, nose and throat, one pre-assessment and two ophthalmic specialist consulting rooms) and a dedicated minor operations suite. The team consisted of

Summary of this inspection

the outpatient manager, outpatient sister, registered nurses, health care assistants and administration support. The department offered a range of outpatient services and included the pre-operative assessment team.

There were 46,822 outpatient total attendances in the reporting period; of these 68% were other funded and 32% were NHS-funded. Overall, outpatient attendances formed 87% of the hospital's activity with daycase discharges forming 10% and inpatient discharges 3%. Children and young people made up 7% of the total outpatient attendances (3,100) and 1% (81) of daycase discharges. Children and young people were not admitted for surgery.

The radiology department included a general x-ray room, a screening room, and ultrasound room, a static MRI unit, a mammography unit, a Dexa unit, two image intensifiers for use in theatre and a mobile x-ray for ward work. The radiology team consisted of contract radiographers, bank radiographers, radiography assistants, medical secretaries and administrative assistants.

The physiotherapy department included seven treatment rooms and a gymnasium. The team consisted of a physiotherapy manager, physiotherapists, a part time physiotherapy assistant and administration support. The team provided inpatient and outpatient physiotherapy services.

There were 273 surgeons, anaesthetists, physicians and radiologists working at the hospital under practising privileges. Two regular resident medical officers (RMOs) were supplied by an agency who worked on a two-week rota. Ashtead Hospital employed 38.7 Full Time Equivalent (FTE) registered nurses, 20.1FTE health care assistants and operating department practitioners and 95.1 FTE other hospital staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

In the reporting period (July 2015 – June 2016), there were no incidents of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) or hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA). There was one incident of hospital acquired E-Coli and no incidents of hospital acquired Clostridium difficile (c.diff).

One serious injury was reported in this period, which is not high when compared to a group of independent acute hospitals which submitted performance data to the CQC.

There were 194 clinical incidents reported, of which 78.4% resulted in no harm, 17.5% low harm, 4.1% moderate harm and 0.5% severe harm. None resulted in death. The overall assessed rate of clinical incidents was lower than the rate of other independent acute providers we hold this type of data for.

In the reporting period, there were 79 complaints. No complaints were referred to the Ombudsman or ISCAS (Independent healthcare Sector Complaints Adjudication Service).

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAGS) accreditation

Services provided at the hospital under service level agreement:

- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Necessary improvements were not always made when things went wrong and learning was not always taken from incidents which had occurred in the outpatients department.
- Patient records in outpatients and children and young people's services were not always complete and sometimes excluded consultant's names, patient condition and treatment. In some cases, the consultant kept original copies of patient records. A new system of record keeping for children and young people did not allow sufficient information to be kept on file that would provide a full record of the patient's treatment.
- Mandatory training compliance was varied and fell below the hospital target in some areas.
- Compliance with child safeguarding training across the hospital was low. A number of staff who specifically dealt with children had not had the face to face element of safeguarding level three training.

However:

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses and were supported when they did so. Staff understood the duty of candour and knew when to apply it.
- Staffing levels and skill mix were planned and reviewed to keep people safe at all times. All clinical areas had an appropriate skill mix.
- The services, wards and departments were clean and staff adhered to infection control policies and protocols. Checklists generally reflected that rooms had been cleaned and equipment was labelled with green 'I am clean' stickers

Are services effective?

Good

We rated effective as good because:

- Staff planned and delivered patient care and treatment in line with current evidence-based guidance, standards, best practice and legislation. This evidence based guidance, standards and legislation underpinned the Ramsay Corporate policies, as reflected by the bibliography of references attached to each clinical policy and discussions with staff.

Summary of this inspection

- The learning needs of staff to develop in role were identified at appraisal and training was encouraged to meet these learning needs. The hospital's commitment to additional training was a thread throughout our conversations with staff.
- Staff worked collaboratively to share best practices and meet the patient's needs. We saw multi-disciplinary working across departments and with other Ramsay Hospitals.
- The hospital had developed a good link with a specialist children's hospital in order to discuss infection prevention and control issues.

However:

- In the outpatients department, patient outcomes were not measured or audited. The hospital did not carry out audit activity relating specifically to children and young people.
- While additional training to develop their roles and abilities was encouraged, it was not clear that all staff had the core skills they needed to carry out their roles effectively and in line with best practice because a substantial portion of staff had not completed mandatory training.

Are services caring?

Good

We rated caring as good because:

- Feedback from patients was continually positive about the way staff treated people. We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff.
- We saw staff listening to each of their patient's concerns and responding in a way that reflected they understood and acknowledged the patient's medical, personal and social needs

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered to meet local needs. For instance, the hospital identified areas where there was patient demand for outpatient services in a variety of areas such as a GP service and ear syringing.
- The hospital offered appointments to meet the needs of the patients, including evening and Saturday appointments. Patients and staff reported that the hospital was flexible and accommodated patient choice. The hospital met or exceeded target appointment wait times and appointments generally ran to schedule.

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- Support and adaptations for patients living with dementia or a learning difficulty were innovative and supported their needs. For example, the use of the dementia butterfly scheme.
- Physiotherapy appointments for children were scheduled with a physiotherapist who had paediatric competencies and a special interest in the particular condition to be treated. Appointments for children and young people attending for an MRI that involved cannulation were scheduled for a time when the paediatric lead nurse was on duty.

However:

- There were very few toys for children to play with in the children's waiting area.
- There were no paper complaints forms in the outpatients department.

Are services well-led?

Good

We rated well-led as good because:

- Leaders were visible around the hospital and staff told us about being supported and feeling part of a team. There were clear lines of accountability in each department and staff had an understanding of their responsibilities and the management structure.
- There was a culture of innovation through learning and training at the hospital. Development opportunities and clinical training were accessible and there was evidence of staff being supported and developed in order to improve services provided to patients.
- The provider had a clearly defined set of corporate values identified as 'the Ramsay Way'. Staff in all of the departments reflected their holistic understanding of the integrating of safety, quality and care equating to high performance.

However:

- Governance processes and strategies required strengthening.
- There was no evidence of a strategy or vision specifically for children and young people. There was no group across the hospital to look at the care provision for children and young people, nor was there a Head of Department for children and young people.

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
Services for children and young people	Requires improvement	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

We rated this hospital as good overall. Although some elements of the children and young people's service required improvement, the overall standard of service provided throughout the hospital was largely good. Since the children and young people's service represented only 3% of the hospital's total activity, we have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and is reflective of a proportionate judgment.

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as good.

Incidents

- The hospital reported one Never Event in the reporting period. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The never event occurred when a patient underwent elective surgery on their spine and the surgery was performed on the wrong level of the spine.
- We reviewed the root cause analysis (RCA) of the never event and saw that a thorough investigation was undertaken, with learning identified, an action log and staff were highlighted who were responsible for ensuring the actions were undertaken and within an agreed time frame.
- Staff were able to give us examples of changes to practice because of the never event. For example in the way the x-rays were taken prior at the start of the operation to confirm the correct site for surgery.
- In the Provider Information Return (PIR), the provider reported one serious injury in the reporting period; however the CQC has a record of three. This could indicate that the hospital did not keep accurate records of these. The number of serious injuries was not high when compared to a group of independent acute hospitals that the CQC held data for.
- Staff gave us two examples of two serious injuries; one was when drugs were mixed together incorrectly during surgery which resulted in the wrong strength being given to the patients who suffered complications as a result. The other serious injury was when a patient suffered a burn during surgery from a light source left turned on which was on the patient. Staff were able to give us examples of learning from these serious incidents for example, there was a new process which ensured the light source was not left turned on whilst on a patient.
- The hospital followed the Ramsay Healthcare UK Incident Policy, which was in date and due for review in 2019. The policy required staff to report all incidents and near misses on the electronic incident recording system. The policy defined responsibilities in accordance with individuals' roles and required staff to report any incident, register the incident on the electronic incident recording system and participate in investigation and corrective actions as required.
- The reporting period referred to throughout this section is July 2015 through June 2016 unless otherwise stated.
- There were 194 clinical incidents reported at the hospital in the reporting period. Sixty-five percent of these incidents occurred within surgery or inpatients. Of all incidents 78% resulted in no harm, 17.5% resulted in low harm, 4% resulted in moderate harm and 0.5% resulted in severe harm.
- The hospital reported 0.5% of all incidents as severe or death. The assessed rate of clinical incidents in surgery and inpatients for the same time period was lower than the rate of other independent acute providers the CQC held data for.

Good

Surgery

- The provider was asked to resubmit a breakdown of clinical incidents by degree of harm (195) as there was a discrepancy when compared to the total amount of clinical incidents in surgery, inpatients and other services (194), however this was not received.
- There were 45 non-clinical incidents reported during the reporting period, 56% (25 incidents) occurred in surgery or inpatients. The assessed rate of non- clinical incidents in surgery and inpatients during the time period was similar to the rate of other independent acute providers the CQC held data for.
- A system and process for reporting incidents was in place. Staff understood the mechanism of reporting incidents. The form was accessible for all staff via an electronic online system.
- Staff told us they received feedback directly if they were involved in an incident or at their team meetings where incidents and complaints were discussed. Learning from incidents was shared at the morning theatres meetings, at integrated clinical governance meetings, medical advisory committee (MAC) and at unit meetings. We saw minutes from these meetings, which confirmed incidents were a standard agenda item.
- Unit meeting minutes were kept within each department and staff were required to sign to say they had read them. This meant staff who did not attend the meetings were aware of incidents and learning points discussed at meetings.
- Some heads of departments (HODs) had undertaken Ramsay Healthcare UK RCA training. There were plans to ensure all HODs undertook the RCA training. This would ensure that there was a consistent method of investigating and report writing within the hospital. We spoke to the theatre manager who had recently undertaken the training who confirmed it was thorough and useful.
- Incidents were reviewed by and investigated by an appropriate manager (depending on the department in which the incident took place).They were also investigated through a RCA, with outcomes and lessons learned shared with staff. We saw five RCA investigation reports, which had been completed, they varied in the amount of detail, recommendations and action plans. This showed there was not a standard template for undertaking RCAs.
- Staff were able to give us examples of changes in practice as a result of RCAs following incidents. For example, an incident occurred in theatre when drugs were mixed together incorrectly, which resulted in a much higher dose of a drug being administered. Staff explained how theatre staff were no longer allowed to mix more than two drugs together without the direct supervision of a doctor. In addition, theatre staff had undertaken refresher training in drug administration.
- Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which related to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened. We saw evidence in RCAs that duty of candour had been applied when applicable.
- Ashtead Hospital reported seven expected deaths in the reporting period, we saw that the deaths were discussed and any learning identified at the MAC meeting minutes.
- The hospital did not carry out specific morbidity and mortality review meetings, due to the low numbers of patients treated and the resulting low numbers of patients who would fall into this category.

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

- The NHS safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- Patients identified at risk were placed on an appropriate care plan and were monitored closely by staff. For example, if a patient was at risk of having a fall a motion sensor mat would be placed on their bed, this notified staff electronically when the patient had got out of bed.
- The hospital reported one case of hospital acquired venous thromboembolism (VTE) in the reporting period.

- The hospital reported six patients falls, three catheter associated urine infections and one pressure ulcer in the reporting period.
- We saw that safety thermometer data was displayed on ward areas, this meant staff and patients were easily able to see up to date information, for example, when the last patient fall was.

Cleanliness, infection control and hygiene

- There were no surgical site infections resulting from revision hip arthroplasty, revision knee arthroplasty, upper GI and colorectal, urological, cranial or vascular procedures.
- The provider reported 19 surgical site infections (SSIs) in total between July 2015 and June 2016.The highest SSI rate (47%) related to spinal surgery.
- We spoke to the infection prevention and control (IPC) nurse regarding the high SSI rate. They explained that every swab taken that tested positive for bacteria was reported to the integrated clinical governance performance committee. However, not all positive swabs indicate the presence of an SSI, and therefore the high SSI rate may not be a true reflection of the actual amount of SSIs that occurred. For example, a positive result might be bacteria naturally present on skin. The IPC nurse said they had raised the issue with the matron previously however, the managers would rather report all positive swabs to ensure any themes were identified. Therefore the 19 SSIs reported were not all actual surgical site infections but indicated a positive swab for bacteria rather than the presence of active infection.
- The rate of infections during primary hip arthroplasty and other orthopaedic and trauma procedures was similar to the rate of other independent acute hospitals the CQC held data for.
- The rate of infections during primary knee arthroplasty, spinal, breast and gynaecology procedures was worse than the rate of other independent acute hospitals that the CQC held data for.
- We saw completed RCAs were undertaken when there was a SSI. The hospital had quarterly IPC meetings and we saw from meeting minutes the RCAs were discussed in these meetings.
- The IPC lead had recently left the hospital but was providing cover one day a week whilst the hospital recruited a replacement. There were IPC link practitioners in the different departments who attended meetings and disseminated information to staff in their areas. IPC issues and updates were a standard agenda item on department meetings.
- The IPC lead undertook hand hygiene training with the staff. In the training, an ultra violet (UV) light device was used to demonstrate how germs were spread.
- The provider reported no infections of Meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile or Meticillin sensitive Staphylococcus aureus between July 2015 and June 2016.
- We saw staff followed the Ramsay Health Care UK Infection Prevention and Control policy, which was in date and due for review May 2019. During our inspection, we saw 12 members of staff wash their hands and 11 members of staff use alcohol hand sanitiser in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'. We saw hand sanitiser bottles readily available throughout clinical areas in theatres and on the wards.
- The hospital undertook monthly hand hygiene audits the April 2016 audit showed 96% compliance. This provided assurances that staff were adhering national guidance and Ramsay Health Care UK policy.
- We saw personal protective equipment (PPE), was used and readily available in ward areas and in the theatres alongside a poster advising of correct PPE procedures. Personal protective equipment is protective clothing such as aprons, gloves, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.
- We found equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection control. All equipment we saw had 'I am clean' labels on them, which indicated the date the equipment had been cleaned and was safe to use.
- All members of staff we saw in clinical areas were bare below the elbows to prevent the spread of infections in accordance with national guidance.

Good

Surgery

- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection (2008) was followed. This included skin preparation and management of the post-operative wound.
- The hospital undertook an audit in April 2016 which showed 99% compliance with NICE guideline CG74. This provided assurances that staff were adhering to national guidance.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we witnessed staff using these.
- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. The clinical waste unit was secure.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked eight sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability. We saw in theatres, the sharps bins were on wheels, this meant the bin could be moved to the patient and sharps could be disposed of immediately.
- There were ward, department and theatre cleaning checklists. The checklist set out checks to be undertaken daily, weekly and monthly; all the checklists we reviewed were complete.
- Domestic staff employed by the hospital undertook the cleaning, and there were processes in place, which ensured communication. For example, in theatres the domestic staff had a “pigeon hole” where information could be left for them.
- In theatres, we saw there were IPC resource folders, which contained information for staff regarding IPC and contained contact details if advice was required.
- The computer keyboards within theatres were wipeable, which reduced the risk of spreading germs.
- There was access to a microbiologist for advice 24 hours a day seven days a week.
- Decontamination and sterilisation of instruments was managed in a dedicated facility within theatres. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics.
- Carpets were made up of removable squares, this meant if something was spilt on the carpet, the square was removed and replaced.
- We spoke with a pre-assessment nurse, who told us the unit screened and risk assessed all patients for MRSA. Only those considered high risk of carrying MRSA were swabbed, for example patients who have previously had MRSA. We saw inpatients records completed pre-operative questionnaires, which included completed risk assessments.
- The hospital had three operating theatres, all had laminar flow theatre ventilation (a system that circulates filtered air to reduce the risk of airborne contamination), which was best practice for ventilation within operating theatres, and particularly important for joint surgery to reduce the risk of infection. Records were kept of the maintenance and ventilation revalidation results, this was in line HTM 03-01 2007.
- There was an annual deep cleaning programme within theatres, which was undertaken by an external company.
- Staff transported dirty endoscopes from the procedure room to the dirty area in a covered, solid walled, leak proof container in line with Health and Safety Executive standards for endoscope reprocessing units.
- A clear decontamination pathway for endoscopes was demonstrated. Dirty areas were accessed from the corridor and clean areas from the surgical area. This ensured no cross contamination from clean and dirty areas.
- We saw that there was a washing sink and a rinsing sink as well the washer machine. Chemicals were released into the sinks via a pre-programmed pump ensuring the correct dose was released for each clean.
- As well as a visual check for leaks by staff during initial cleaning, the wash machine was also able to carry out leak tests on the scopes.

- Staff kept full scope-tracking and traceability records. These indicated each stage of the decontamination process. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).
- Testing of all washers was done on a daily basis. Filters were checked once a week. All equipment in the washing room was regularly serviced. We saw clear information about when the next service was due ensuring staff knew the equipment they were using was safe.
- The hospital had a system for managing the risk of Legionnaire's disease. Legionnaire's disease is a lung infection caused by Legionella bacteria. Legionella bacteria is spread when water supplies become contaminated with the bacteria which is more likely in larger, more complex water systems such as those found in hospitals.
- We spoke with three members of the facilities team including the manager. They explained that the hospital managed the Legionella risk by flushing all taps throughout the hospital daily and testing the water for Legionella bacteria quarterly and thermostatic mix valves (mixes the hot and cold water supplies to produce a temperature-controlled flow) twice yearly. We saw the twice yearly tests were on the facilities planned preventative maintenance schedule. The flushes were performed by hospital facilities employees and the testing was performed by an outside contractor.
- The employees who flushed the taps daily received e-learning regarding the risks of Legionella. This meant staff understood why the taps needed to be run on a daily basis.
- We reviewed the Legionella logbooks, which showed the quarterly water testing between January 2016 and September 2016, all records were complete. The test results were satisfactory for the first two tests but there was an unsatisfactory result for one ground floor tap in the third test. To address this, the hospital replaced the tap and retested. The retest certificate reflected satisfactory testing results.
- The thermostatic mix valves were tested twice a year to provide assurances that the water was the right temperature. The test log reflected that water temperatures were within the correct temperature range.
- There were no dedicated hand washing basins in patient bedrooms, staff and visitors used the basin in the bedroom's ensuite bathroom or the handwashing facilities in the sluice. This is not in accordance with the Department of Health's (DoH) Health Building Note (HBN) 00-09: infection control in the built environment, which states 'Clinical wash-hand basins should be provided in addition to the general wash-hand basin provided for patients. The hospital told us they were aware of the lack of dedicated hand washbasins in patient bedrooms, and the installation of new hand washbasins was included in their programme of works.
- Ward staff described to us using aseptic techniques when changing a dressing using a non-touch technique to avoid any cross infection. This was in line with NICE guidance (QS49).
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patient representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance. In the most recent PLACE assessment for cleanliness the hospital scored 98%, which was equal to the England national average.

Environment and equipment

- Endoscopy services were being delivered in-line with the British Society of Gastroenterology guidance and had achieved Joint Advisory Group on Gastro-intestinal Endoscopy (JAG) accreditation.
- The endoscopy suite was separate from other areas. It had separate clean and dirty utility areas and was designed to facilitate flow from dirty to clean areas. This demonstrated adherence to the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope Reprocessing Units, QPSD-D-005-2.2.

Good

Surgery

- There were processes to ensure endoscopes (an instrument used to examine the interior of a hollow organ or cavity of the body) were decontaminated and the risk of infection to patients minimised.
- Staff told us the number and size of endoscopes met the needs of the service. We saw a range of scopes available to perform a variety of examinations.
- We reviewed the cleaning records of the endoscopes which were all compliant with patient traceability, so it could be traced which endoscope was used on each patient.
- We saw there were records of six monthly service visits of the endoscope washers and quarterly water samples taken to be tested for the presence of bacteria.
- The hospital undertook an audit in April 2016 which showed 93% compliance adherence to standard operating procedures and policies within endoscopy.
- Chemicals used for cleaning of endoscopes had batch numbers recorded in a logbook so any issues could quickly be resolved. Chemicals were mixed each day.
- The hospital undertook an audit in April 2016 which showed 100% compliance in relation to the correct storage of endoscopes.
- The unit was air conditioned and as part of planned building works, a new air filtration system was planned to further improve the environment.
- We saw there was an adequate number of portable oxygen cylinders for the transfer of patients or for use in an emergency. We checked eight cylinders, which were in date and labelled.
- Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut. There was a hospital generator that was tested monthly; this ensured there was a backup supply of electricity if the main electricity supply failed. We saw records of the generator testing and records of when the generator had been used to supply power to the hospital.
- We saw that electrical safety checking labels were attached to electrical items showing that it had been tested and was safe to use. We checked 43 pieces of electrical equipment and all had been tested within the last 12 months.
- Theatres had a difficult intubation (placing a breathing tube in the windpipe) trolley, which met the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. We saw daily checking records, which were fully completed which gave assurance that the equipment was ready to use in the event of an emergency.
- We saw 'Health and Safety Control of Substances Hazardous to Health' were stored in line with Health and Safety Executive guideline SR24. This ensured safe storage of dangerous substances, which could cause harm to staff, and prevented unauthorised access.
- We checked over 10 consumable (disposable equipment) items and all were within their expiry date, which showed they were safe to use.
- The wards and theatres had portable resuscitation trolleys. The trolleys contained medication and equipment for use in the event of a cardiac arrest. We saw daily check sheets completed for all trolleys to ensure equipment was available and in date. The resuscitation trolleys all had tamper evident tags to alert staff to any potential removal of equipment.
- We saw in theatres that there was a system to ensure the recording of medical implants used. This was in accordance with the Medical Devices Regulations 2002. A medical implant is a device intended to be either totally introduced into the body or to be partially introduced into the body through surgery and to remain there for at least 30 days.
- In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients' operations. This ensured no items were left behind during surgery and was in line with the Association for Perioperative Practice (AfPP) guidelines.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) was consistently adhered to. This guideline stated that records must be kept of each safety check of all anaesthetic machines in a logbook, which is kept with the machine. We examined four log books and all were complete with daily signatures to confirm the safety checks had been undertaken.

- The staff we spoke with confirmed they had access to the equipment they required to meet peoples' care needs.
- There was an outside medical gas cylinder storage, which was compliant with The Department of Health (DOH) The Health Technical Memorandum (HTM)02-01 Part A guideline. This states medical gas cylinders should be kept in a purpose built cylinder store that should allow the cylinders to be kept dry, in a clean condition and secure enough to prevent theft and misuse.
- We inspected the gas manifold room that housed the piped medical gas supply. The room was located at the back of the building. Appropriate signage was in place to notify people what was contained within. The room was locked and this prevented any potential sabotage to the supply of medical gases.
- In the most recent PLACE assessment for condition, appearance and maintenance, the hospital scored 96%, which was better than the England national average (93%).

Medicines

- Staff followed their corporate 'Medicine Management Policy (dated October 2014), which included, roles and responsibilities, storage of medicines in hospital departments, dispensing, controlled drugs and preparation of medicines. The policy referenced national guidance, for example, General Medical Council (2013), Good practice in prescribing and managing medical devices, and Nurse & Midwifery Council (2006), standards for proficiency for nurse and midwife prescribers.
- We checked temperature monitoring charts for the medicine fridges on both wards and in theatres. The records showed staff had monitored the temperature of both fridges daily in the last month. This provided assurance the unit stored refrigerated medicines within the correct temperature range to maintain their function and safety. Staff were able to describe what action to take if the temperature fell outside of the safe range.
- There was a completed daily checklist for monitoring the ambient temperature on the wards and theatres. This ensured that medicines stored at room temperature remained within the manufacturer's indicated temperature range.
- We saw medicines on the wards and theatres were stored safely and securely in line with relevant legislation for the safe storage of medicines.
- We checked the controlled medicines (CD) cupboards. Controlled Drugs are medicines liable for misuse that required special management. We saw the CD cupboards were locked, and we checked a random sample of stock levels. We saw the correct quantities in stock according to the stock list, and that all were in-date. We saw the records for CDs were complete. CD keys were secured within keypad locks in theatres and wards to ensure the security of the drugs.
- The hospital undertook an audit in December 2016, which showed 97% compliance with the storage and administration of CD's. This meant CDs were stored and administered in line with hospital policies and national guidance.
- The Ramsay Health Care UK Group had a quarterly drugs and therapeutics meeting. We saw evidence of these meetings which contained information regarding discussions of National Committee topics and findings.
- There was one full time pharmacist, two part time pharmacists and a pharmacy technician. We saw that the prescription charts had been reviewed by a pharmacist who had documented input regarding medications.
- The pharmacy technicians checked stock levels of medicines on wards and departments daily, and stocked up medicines as required. Staff reported having good access to pharmacists when advice was required and adequate access to medicines.
- The resident medical officer (RMO) and nurse in charge had access to the pharmacy department out of hours.
- We looked at 20 medication charts which were completed comprehensively, dated, signed and had no missing doses. The sample of medication charts we

reviewed showed interventions from a pharmacist. This demonstrated that pharmacists were regularly reviewing medication charts to ensure medicines were correctly prescribed.

- The hospital undertook a medicine audit in November 2016; this showed that 100% of patients had their drug reconciliation recorded within their notes. Medicine reconciliation is the process of creating the most accurate list possible of all medications a patient is taking and comparing that list against the admission, transfer, and/or discharge orders with the goal of providing correct medications.
- In the same audit 100% of patients had a reason documented if the medicine was not given. This meant staff knew the reason why a medicine had not been given.
- We saw a number of audits related to medicines were undertaken; these included the quarterly medicines management audit, missed doses audit and quarterly controlled drug (CD) audit. Recommendations from audits were monitored and completed within required timescales.
- A pharmacist attended the Antibiotic Stewardship meetings and updated staff on practices, which related to the use of antibiotics. This was important as a number of medical patients were admitted for the treatment of an infection and this ensured antibiotic treatment was in line with best practice.
- The hospital undertook an audit in November 2016 which showed that 90% of patients had the reason for requiring antibiotics recorded in their notes. In the same audit 100% of patients had the need for antibiotics reviewed within 48 hours of starting them. This was in line with NICE guideline QS61.
- Patient allergies had been clearly noted on their paper notes, medication chart and on their identity band, which alerted staff to their allergy.
- The hospital undertook a medicine chart audit in May 2016, this showed that 100% of patients had their allergy status recorded (either no known allergy or known allergy).
- Staff followed the corporate Antimicrobial Prescribing and Stewardship and the Antimicrobial Prescribing Policy when treating medical patients with infections. Both policies were in date and referenced national guidance for example, the National Institute for Health and Care Excellence (NICE) and the Health Act 2008: Code of practice for the prevention and control of healthcare associated infections. The policies set out guidance on which antibiotic should be prescribed for specific infections. This meant staff had guidance available for the management of infections.
- The hospital undertook a patient satisfaction survey in quarter two 2016 (1st April- 30th June).This showed that 90% of patients were told how to take their medicines in a way they could understand.
- In the same survey 89% of patients were given clear written instructions on how to take their medicines after discharge from hospital.

Records

- Staff followed the corporate Medical Records Management Policy (issued December 2007) and Security of Medical Records outside a Ramsay Health Care Facility (issued June 2008). Both policies were in date and referenced national guidance for example, the Data Protection Act 1998.
- We looked at 20 sets of patient records. These were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and families.
- Medical records were stored securely in trolleys, by the ward reception areas.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms. This meant that patients were having their individual needs assessed. Records were legible, accurate and up to date.
- The hospital used a number of patient pathway documents, which followed the path the patient took through a specific care episode such as a generic medical admission and day case admissions. This meant specific risks associated with these procedures were assessed. In addition, it meant all relevant information was in one place together which made finding relevant information easier.

- We saw the theatre records section of care plans were clear and safety checks documented to ensure safe surgery and treatment was undertaken.
- We saw a variety of assessments were undertaken. These included patient falls assessment, pressure area assessment and venous thromboembolism assessments.
- All patients undergoing a procedure completed a medical questionnaire as part of their pre assessment.
- A new hospital computer system scheduled for installation in November was delayed; it was anticipated that it would be introduced in 2017. The new electronic patient records would prevent the need for records to be removed from Ashtead Hospital. The new system is electronic and it will be mandatory for consultants, nursing team and other clinical teams to upload their notes to the patient's record and for all of the multi-disciplinary team to access all patient records.

Safeguarding

- Staff followed the corporate Safeguarding Adults at Risk of Abuse or Neglect Policy. The policy outlined staff's responsibility to help prevent abuse and to act quickly and proportionately to protect people where abuse was suspected. The policy was in date and due for review in 2019.
- The theatre manager was the adult safeguarding lead for the hospital and had undertaken additional level three Ramsay Health Care UK training in safeguarding.
- Clinical staff had undertaken level two adult safeguarding training and non-clinical staff had undertaken level one adult safeguarding training.
- There were no safeguarding concerns reported to CQC between July 2015 and June 2016.
- There were flow charts in each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.
- The theatre and ward training tracker did not track safeguarding on-line learning.

Mandatory training (if this is the main core service report all information on the ward(s) here).

- The Ramsay Healthcare UK Mandatory Training policy was in date and due for review July 2018. It outlined mandatory training requirements presented in person or as e-learning including induction.
- The hospital had an induction programme for permanent and temporary staff and a mandatory training plan. There was a combination of on line learning and face-to-face learning.
- The Mandatory Training policy and staff training tracker showed that staff members were required to complete different training depending on their role. These could include varying levels of manual handing, life support, medical gases, venous thromboembolism (VTE) (a condition where blood clots form in a vein), consent, enhanced recovery, intravenous training, drug calculation, blood transfusion and venous collection.
- We saw the training records for staff, which were included within their appraisal. If staff were non-compliant with their training, it would be highlighted at their appraisal.
- Managers were able to show us up to date training records of all their staff, from these it was easy to identify who was not compliant with their training.
- Staff confirmed they were given enough time and support to complete their mandatory training. Staff attended a whole day mandatory training, which included several elements.
- Consultants had to complete mandatory training with the trust they worked for as part of their appraisal process.
- The resident medical officers (RMO) were required to undertake their mandatory and statutory training with the agency that supplied them as part of their contract.

However:

- Mandatory training compliance was varied ranging between 13% and 100% compliance for theatre staff and between 20% and 100% for ward staff. Overall 75% of ward staff were up to date with mandatory training and 81% of theatre staff were up to date. Both were worse than the Ramsay Health Care UK group target of 90%. This could demonstrate that staff did not have current knowledge in critical areas.

Good

Surgery

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

- Patients completed a preadmission questionnaire to assess if there were any health risks which may compromise their treatment at the hospital. Nurses discussed the health questionnaires with patients in the pre-admission clinics or via the telephone. If staff identified a patient as being at risk, they were not accepted for surgery. Assessments included risks about mobility, medical history, skin damage and venous thromboembolism (VTE).
- The hospital did not have any level two or three critical care beds. To mitigate this risk, the unit only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.
- Staff met for a team briefing at the start of each operating list in accordance with the World Health Organisation 'Five steps to safer surgery'. We observed a team briefing, which was comprehensive and discussed each patient to minimise any potential risk. Pre-existing medical conditions and allergies were also discussed to ensure the team was informed alongside any equipment requirements. We witnessed surgeons checking the appropriate equipment was available. The briefings demonstrated that risks were being discussed and any potential issues were highlighted.
- The hospital undertook an audit in December 2016, which showed 100% of staff were present for the 'Five steps to safer surgery'. This demonstrated that all the required staff were present for the safety checks.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment.
- We reviewed 15 completed WHO checklists and all were fully completed. This meant there was assurance that the safety checks had been completed. We observed staff using specific WHO checklists for different procedures, for example endoscopy. This ensured staff checked the most important safety factors relating to a specific procedure.
- The hospital undertook an audit in December 2016 which showed 100% completion of the WHO checklist. This provided assurances that the safety checks were undertaken.
- The hospital used the National Early Warning System (NEWS) track and trigger flow charts. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We reviewed 20 patients' NEWS charts. Staff had completed all 20 accurately and fully.
- The hospital undertook an audit in March 2016 which showed 100% of patients had a NEWS score calculated. This provided assurances that patients were monitored and a NEWS score calculated which highlighted any deterioration in a patient's condition.
- We saw in patients' records that patients had a falls risk assessment, which was in line with NICE guideline CG16.
- There were daily handovers, one at the beginning of the day and the other towards the end of the day. We observed a nursing handover, which was well organised and comprehensive. At the end of handover a safety briefing checklist was used which identified; patients with infections, medication, sick patients, patients at risk of falls, patients identified as potential absconders, same name patients, patients not for resuscitation, hand hygiene, pressure areas, cannula care, documentation assessments and care plans. This meant that staff were informed of patients who might be at an increased risk of harm.
- Emergency blood for transfusion was available within the pathology department, and staff had access to the pathology department 24 hours a day seven days a week. Staff undertook blood transfusion training as part of their mandatory training, 92% of ward and theatre staff were up to date with training.
- The provider reported 14 unplanned transfers of an inpatient to another unit in the reporting period (July 2015 – June 2016).The rate of emergency patient transfers to an acute hospital had remained consistent, and was not high when compared to other similar

hospitals we hold data for. We undertook a review of the unplanned transfers and given the nature and volume of operations undertaken, all were appropriate and there were no common themes or concerns.

- There was a service level agreement with a local NHS trust, for unplanned patient transfers. Staff we spoke with were familiar with the escalation process and where necessary, patients were transferred by ambulance. We saw flow charts displayed which showed what actions staff should undertake when a patient required transfer. This meant there was a clear process for staff to follow.
- There were 11 unplanned returns to the operating theatre for the same time period. We undertook a review of these; there were no common themes and had all been treated appropriately.
- Nursing staff told us medical support was readily available when required as the Resident Medical Officer (RMO) attended to patients quickly.
- A RMO told us that there was an effective support process in place should they require support or advice. They gave several examples of when patients had suffered complications and how support and advice was available quickly, initially via telephone and then the consultant would attend the hospital if required.
- We saw 'avoid a fall nurse call bell' posters, which encouraged patients to press the call bell and request assistance rather than risk having a fall. We saw all patients had their call bell within reach, and patients told us if they pressed it, they were responded to almost immediately.
- We saw there were a variety of up to date clinical standard operating procedures in the management of emergency situations for example massive blood loss and the management of the deteriorating patient. These ensure a standardised approach to managing emergency situations. Staff we spoke to confirmed they had access to these and were aware of the content.
- The hospital used a communication tool called Situation Background Assessment Recommendations (SBAR) (a technique that can be used to facilitate prompt and appropriate communication) for both medical and nursing staff to use when escalating concerns about a patient's condition. We observed the use of SBAR during our inspection.
- Staff told us they checked the pregnancy status of female patients of potential childbearing age on the morning of planned surgery by undertaking a pregnancy test. We saw the results of the test were documented on the pre-operation checklist.
- The hospital used a visual phlebitis-scoring tool for monitoring infusion sites and is recommended by the Royal College of Nursing (RCN). We saw Visual Infusion Phlebitis (VIP) scores had been undertaken and correct action taken in the patient records we reviewed. This meant the need for intravenous (administered into a vein or veins) devices, signs of infection and comfort of the devices were reviewed on a regular basis.
- We saw all patients had a VTE assessment completed and all patients wore anti-embolic stockings. The purpose of anti-embolism stockings is to reduce a person's risk of developing venous thromboembolism.
- We saw that when patients were collected for their operation or procedure a slip was used by the staff, which contained the patient's name, date of birth and hospital number. In addition, on the slip was a checklist of assessments that had to be undertaken prior to leaving the ward for example VTE. This demonstrated a process to ensure all relevant assessments were undertaken prior to a patient's procedure or operation.
- The hospital used intentional rounding by nursing staff, which was completed throughout the patient's stay. This meant patients were visited in their rooms hourly to check, for example, if call bells and a drink were in reach, if the patient had pain or had any other requests. We saw evidence in patients' records of rounding.
- There were alarm systems to alert medical and nursing staff when immediate assistance was required in the case of an emergency.
- Medical patients were not admitted to the ward after 7pm which ensured there was an appropriate level of staff available to assess and treat medical patients.
- We saw that both surgical and medical patients with a suspected sepsis (infection) were treated in line with Sepsis Six. Sepsis Six is the name given to a bundle of

medical therapies designed to reduce the mortality of patients with sepsis, it consists of three diagnostic and three therapeutic interventions all to be undertaken within one hour of the initial diagnosis of sepsis.

Nursing and support staffing

- The ward manager utilised the Shelford Model as the staffing tool to review the acuity of patients, this is a predicted occupancy tool, which reviews patient acuity regularly throughout the day. Staffing provision was managed through a computer software system, which was reviewed on a daily basis, and staffing ratios adjusted accordingly. In addition, a computer software system was used to ensure safe skill mix with a senior nurse on each shift.
- On the day of our visit, we saw staffing levels met the Association for Perioperative Practice (AfPP) guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We reviewed previous rosters, which demonstrated that this guideline was adhered to.
- As of 01 July 2016, there was 19 whole time equivalent (WTE) nursing staff employed in theatres and the ward and 9.8 WTE health care assistants (HCAs) and operating department practitioners (ODPs).
- The use of bank and agency nurses in theatres and ward was less than the average of other independent acute hospitals we hold this type of data for in the reporting period (July 2015 to June 2016), except for in April 2016 and May 2016.
- The use of bank and agency ODPs and health care assistants in theatre departments was

  variable throughout the same reporting period. Rates were worse than the average of other independent hospitals we hold this type of data for in November 2015 to February 2016 and in April 2016 to June 2016.
- There were no vacancies for inpatient nurses, health care assistants or other staff within theatres and the ward as at 1 July 2016.
- Staff we spoke with told us they had enough staff on duty at all times to deliver good individualised care to all patients even though they could sometimes be very busy.
- Nursing staff rotated between caring for surgical patients and medical patients, which meant they were flexible and kept all their skills up to date.
- The hospital told us, and staff confirmed, there was always a duty manager on call out of hours, to provide support.

Medical staffing

- All patients were admitted under the care of a named consultant. There were 273 consultants who had been granted practising privileges at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at other NHS trusts in the area.
- The Resident Medical Officer provided continuous medical cover and conducted regular ward rounds to ensure that all patients were appropriately treated and safe. Any changes in a patient's condition were reported to the consultant and their advice was followed in respect of further treatment.
- The hospital had two RMO's who were employed by an external agency and provided immediate medical support 24 hours a day seven days a week. They slept on site and worked a shift pattern of two weeks on and two weeks off.
- We spoke to a RMO who confirmed support from consultants was always available and gave examples of when advice had been given via the telephone prior to attending the hospital. A RMO told us that consultant lead care was available out of hours and at weekends.
- Staff told us that a formal hand over process was undertaken between RMO's however, we did not see this as there was no change over during our visit.
- We observed, and staff confirmed that the surgeon was available for 30 minutes immediately after a procedure or operation before leaving the hospital in case any complications occurred. After leaving the hospital, they were available by telephone 24 hours a day as they maintained responsibility for the patient for the

duration of the patient's stay. We were informed that the anaesthetist was available via telephone for advice for 24 hours following a patient's procedure. Staff reported that they did not encounter difficulties contacting the relevant anaesthetist during this post-operative period.

Emergency awareness and training

- The hospital tested its fire alarm on a weekly basis. We reviewed the fire safety book, which verified regular fire drills and reflected that in the last fire drill the rates of evacuation, procedures and communications were all rated as 'good'. Good was the best outcome on a scale from poor to good.
- Scenario based training was held regularly which ensured staff responded appropriately to emergency situations. For example, staff told us these included a massive haemorrhage (blood loss) scenario. Staff told us that they enjoyed taking part in the scenario training and found it extremely useful as it was rare they would experience such emergencies and it kept their skills up to date.
- There was a Ramsay Health Care UK business continuity plan part A and B, which was in date. The purpose of the policy was to counteract interruptions to Ramsay Health Care UK business activities and to protect critical business processes from the effects of major failures or disasters. Staff demonstrated accessing this policy and were aware of the content and what actions to take.
- Staff were not all up to date with their mandatory life support training. The training tracker showed that in theatres 73% of required staff were up to date with intermediate life support (ILS) and 75% of ward staff were up to date with ILS training. This was worse than the Ramsay Healthcare Mandatory Training Policy target of 90% compliance. This meant not all staff had up to date life support skills and knowledge.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Generally, care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines.
- In theatres, and in the patient notes, we saw evidence of providing care and treatment in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic liquid.
- We reviewed 20 patient records, which all showed evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in unit- recognising and responding to deterioration.
- The national early warning system (NEWS) was used to assess and respond to any change in a patient's condition. This was also in line with NICE clinical guideline CG50.
- We saw in the patient records we reviewed completed venous thromboembolism (VTE) assessments in accordance with NICE clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to surgery'. The hospital consistently met their NHS contracted 95% target screening rate for VTE risk assessment in the reporting period (July 2015 – June 2016).
- There were specialist clinical pathways and protocols for the care of patients undergoing different surgical procedures. For example, there was a generic medical admission pathway.
- Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the intranet.

- We saw meeting minutes, which confirmed monthly meetings included NICE guidelines and compliance was discussed. In addition, there were ward staff meetings but we noted these only occurred every three months.
- Patients' temperatures were measured and documented in accordance with inadvertent perioperative hypothermia, NICE guidance clinical guideline CG 65. However, audit data from June 2016 showed that only 63% of patients had their temperature taken every 30 minutes whilst undergoing an operation. We saw in the theatre meeting minutes that this had been highlighted and staff had been reminded to do this. We saw patients' temperatures were undertaken every 30 minutes during our inspection.
- We saw the hospital had recently implemented NICE guidelines CG42, Dementia: supporting people with dementia and their carers in health and social care.
- The hospital provided data to the National Joint Registry (NJR). The NJR collected information on all hip, knee, ankle, elbow, and shoulder replacement operations to monitor the performance of joint replacement implants.
- The hospital also provided breast surgery. The hospital had signed up to contribute information for inclusion in the national Breast and Cosmetic Implant Registry (BCIR). Similar to the NJR, the purpose of the BCIR was to monitor the performance of implants, specifically breast implants. National implementation of the BCIR was due to take place in September 2016, but due to problems with the website, this had been delayed. However, the hospital kept a local register in preparation for transfer of records to the BCIR once this was launched. This was in line with best practice guidance.

Pain relief

- The pre assessment lead told us that patients were counselled on pain management as part of the pre assessment process. Patients we spoke to confirmed different pain relief had been discussed at pre assessment. In addition, patients confirmed take home pain relief medicines were also discussed. This meant patients were informed regarding pain relief prior to their procedure.
- We observed that consideration was given to the different methods of managing a patient's pain, including patient controlled analgesia (PCAs) pumps. PCA is a method of allowing a person in pain to administer their own pain relief.
- Nurses on the medication rounds would ask each patent if they were in any pain and would give prescribed analgesia if necessary.
- An audit undertaken by the hospital in November 2016 demonstrated that 100% of patients had their pain assessed when staff were undertaking their observations, for example blood pressure. This showed that patients were undergoing regular assessments of their pain.
- We spoke to five patients who had recently undergone surgery. All told us their pain was well controlled and said nurses responded quickly when they requested additional pain relief.
- We saw potent pain relief was prescribed for the immediate post-operative period when the patient was in recovery. This meant if a patient woke up from the anaesthetic and experienced pain it could be administered to the patient quickly rather than it having to be prescribed.
- The department used two recognised pain assessment tools. Patients were asked to rate their pain between one and 10, one meaning no pain and 10 being extreme pain. The second pain assessment tool was for patients receiving a patient controlled analgesia (PCA) then a pain score of zero and three was used, zero meaning no pain and three being extreme pain .
- The hospital undertook an audit in November 2016 which showed 100% of patients had written evidence that the pain assessment tool was used in recovery. This demonstrated that patients pain was assessed using the recognised tool immediately after their surgery.
- One of the pharmacists had set up a pain management group within the hospital, which reviewed pain control regimes and the latest guidance regarding the management of pain. The group had input from other wards and departments for example, an anaesthetist.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess a patient's risk of malnutrition and if a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician. Ward staff made referrals to dieticians at a NHS hospital for review when required.
- There was a process to ensure patients were appropriately starved prior to undergoing a general anaesthetic. Each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum. Patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, which was in line with best practice. Patients were telephoned the day before their operation when the order of the operating list was known and told what time to stop eating and drinking.
- We saw there were two different menus available, one for private patients and one for NHS patients. Both menus had a variety of different food available and the top 10 allergens were identified on the menu which was in line with the Food Standard legislation.
- Patients we spoke to said they were offered enough to eat and drink and said the quality and variety of food offered was very good. All the patients we observed had water jugs on their bedside table so could access drinks at any time.

Patient outcomes

- The hospital reported six unplanned readmissions within 28 days of discharge in the reporting period. The assessed rate of unplanned readmissions (per 100 inpatient and day case attendances) was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- The hospital provided data to the national Patient Reportable Outcome Measures (PROMs). All NHS patients having hip or knee replacements, varicose vein or groin hernia surgery were invited to fill in PROMs questionnaires. The PROM questionnaire asks patients about their health and quality of life before they have an operation, and about their health and effectiveness of the operation afterwards.
- The hospital provided PROMs data for primary knee and hip replacements. The data showed patient outcomes for hip and knee replacements were equal to or better than the estimated range.
- PROMs data for groin hernia showed patient outcomes were equal to the estimated range.
- The adjusted average health gain for PROMs for varicose vein could not be calculated, as there were fewer than 30 modelled records.
- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS.
- Data was also submitted to the Global Rating Scale as part of Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
- The 2015/16 annual JAG report showed that no patient awaiting an endoscopy procedure breached the six week waiting time for diagnostic or surveillance procedures.
- The same report showed there was one unplanned readmission within eight days after an endoscopy procedure.
- Comparative outcomes of consultants were measured locally via local audit, and the Ramsay Health Care Ltd via information sharing.

Multidisciplinary working

- The ward liaised with district nurses to arrange ongoing care for patients post-discharge where appropriate. We saw there were contact details of whom and how to contact GP's and district nurses if required.
- Daily ward rounds were undertaken seven days a week. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors, physiotherapists and the pain team.
- We observed 'team briefings' in theatres that were held prior to the start of operating lists. Surgeons, anaesthetists, and theatre staff attended these. These 'briefings' allowed the team to review the operating list together and highlight any particular issues.

- We observed a good working relationship between the pharmacist, resident medical officer and nursing staff on the ward.
- The preoperative assessment nurses liaised with anaesthetists and surgeons to coordinate preoperative investigations; including confirming what assessments were needed and following up the communication once, results were known.
- We saw physiotherapy staff on the ward going to see patients and witnessed effective communication between physiotherapy staff and nurses. Patients were given specific exercises to do by the physiotherapist and we saw a physiotherapist explaining these to a patient.

Seven-day services

- The hospital was open seven days a week 24-hours a day to care for medical and surgical patients who needed to stay in hospital overnight and at the weekend.
- As part of the practising privileges granted and the Ramsay Healthcare facility rules, consultant surgeons and consultant physicians (who look after medical patients) were required to be available at all times whilst their patient was an in-patient or in the hospital as a day patient and were required to be no more than 30 minutes from the hospital.
- Each consultant was responsible for the pre-arrangement of cover with a colleague and should they have planned or unplanned absence, the ward team must be notified to ensure continuity of patient care. Anaesthetists were responsible for their patient for the first 24 hours following surgery. If a patient required an anaesthetic review, following this period the surgeon would contact the anaesthetist or another anaesthetist.
- Some surgeons undertook regular operating sessions on Saturdays. This meant patients could have their operations on a Saturday, however this was not routine for all types of operation.
- The diagnostic imaging department provided 24- hour a day, seven days a week service for urgent examination request, via an on call system. This allowed staff to access diagnostic services in a timely way to support clinical decision-making. For example, if a medical patient with a chest infection needed a chest x-ray.
- Bank physiotherapists covered Saturdays and Sundays and there was a list of physiotherapist who could be called in if required. For example, a medical patient required chest physiotherapy for a chest infection.
- Either a pharmacist or pharmacy technician (with phone access to a pharmacist) provided an on-call service 24 hours a day seven days a week. There were appropriate processes in place for staff to obtain medication from the pharmacy department out of hours.

Access to information

- Patient records were kept on site and access was available 24 hours a day seven days a week. During the inspection, we requested access to patient records and they were supplied quickly.
- Discharge letters were sent to a patient's general practitioner (GP's) on the day of discharge with details of the treatment or procedure completed, follow up arrangements and medicines provided. A copy was given to the patient on discharge, which ensured continuity of care for the patient once discharged.
- Test results, including x-rays, were held electronically. The consultants and RMO had access to these as required.
- We saw that discharge arrangements were started as soon as possible. This meant patients felt fully informed for all parts of their recovery.
- Patients were informed of their operation or procedure at pre assessment and given information to take away and read. For example, there were specific procedure information leaflets. This meant patients were informed of their procedure and would know what to expect on the day of surgery.
- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with their doctor and nursing staff.
- The hospital undertook a patient satisfaction survey in quarter two 2016 (01 April- 30 June). This showed 90% of patients were given written information about what to do after discharge from hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

- Ramsay Health Care had consent to treatment for competent adults and children and young people policy, which was current and due for review in 2019. The policy outlined the rationale, responsibilities and processes for consent, and listed the four applicable consent forms and four information leaflets for patients about consent.
- Consent training was part of mandatory training; 100% of theatre staff had undertaken consent training, which was better than the Ramsay Health Care target of 90%, but only 56% of ward staff had undertaken this, which was worse than the Ramsay Health Care target. This provided assurance that the theatre staff were informed on the consent taking process but ward staff may lack knowledge.
- Patients we spoke with told us they were given as much information as they required from their consultant prior to their operation, to enable them to give informed consent to the procedure. Any risks with regard to the operation or procedure had been explained to them.
- We reviewed 14 consent forms for surgery. Patients and staff had fully completed, signed and dated the consents to ensure they were valid. The consent forms did not contain any abbreviations that a patient may not have understood.
- An audit undertaken in September 2016 confirmed our findings, 100% of consent forms used terminology that could be understood by the patient.
- In the same audit, 90% of patients were given a signed copy of their consent form. This meant they had a copy, which they could refer to if required.
- Ramsay Healthcare had a Deprivation of Liberties Safeguards policy, which was current and due for review in 2019. The policy defined deprivations of liberties and associated terms. It outlined the procedure for making a deprivation of liberties decision, requesting authorisation, review of authorisation, and the role of the Relevant Personal Representative (RPR). The appendices included a mental capacity and best interest assessment form, a risk assessment form and a list of other relevant forms.
- The policy did not require specific training but it made the registered manager responsible for ensuring training was in place. The training tracker did not reflect any information about MCA and DOLs training or provide any compliance rates .This could mean that staff were not up to date with the latest guidelines and procedures.
- Staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLS) and were able to describe the arrangements that were in place should the legislation need to be applied**.** However, staff said they rarely had patients that this applied to.
- We saw safeguarding and MCA flowcharts posted on staff noticeboards in the ward areas.
- Patients undergoing cosmetic surgery were required to have a two week cooling off period between their consultation with the surgeon and their operation. A staff member demonstrated on the computer system where this applied to patients undergoing breast augmentation (implants).This showed that the two week cooling off period was adhered to.
- Staff followed the Ramsay Health Care had a resuscitation policy which was in date. The policy clearly identified the process for decisions relating to do not attempt cardiopulmonary resuscitation (DNACPR) orders. Patients' resuscitation status was assessed and documented pre and during their admission. During our review of patient records, we saw one DNACPR order which was completed fully and appropriately.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- The NHS Family and Friends Test is a satisfaction survey that measures a patient's satisfaction with the care they have received. Data for all patients from January to June 2016 showed the hospital had scores similar to the England average and response rates were above the England average for NHS patients. This showed that most patients were positive about recommending the hospital to their friends and family (England scores and response rates are for Independent Sector (IS) NHS patients only).

Good

Surgery

- Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) QS15.
- We spoke to 10 patients, who were a mixture of surgical and medical patients. All patients said they were happy with the standard of care they had received.
- We observed many positive interactions between staff and patients during our inspection. We witnessed staff approach people rather than waiting for requests for assistance. All staff introduced themselves with "My name is". We saw staff knocked on the patient's room door before entering and asked patients what name they would prefer to be called.
- One member of staff said they would do anything to help improve a patient's experience and said, 'they might only be little things to us but they are big things to them'. This showed staff would try to accommodate any request from a patient.
- We received two comment cards from patients who had recently received care at the hospital. Both were positive and included these comments 'I was treated very well by the nurses, physiotherapists, and all staff at Ashtead hospital they are angels' and another patient said, 'Everybody is understanding, sympathetic and caring'.
- We saw in theatres consideration was given to preserving a patient's dignity, for example not opening theatre doors until patients were covered.
- We saw thank you cards with plaudits for staff displayed on wards. Ward areas had 'You said we did' boards, displaying actions taken following patient feedback.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2016 scored 74% for privacy, dignity and wellbeing at Ashtead hospital, which was worse than the national average of 83%. However, during all of our observations during inspection we found patients privacy and dignity was maintained.
- In addition, the hospital undertook a patient satisfaction survey in quarter two 2016 (01 April- 30 June) which showed 99% of patients felt they were treated with dignity and respect.

Understanding and involvement of patients and those close to them

- We spoke with 10 patients, who all told us they had been kept well informed at every stage of their care.
- We saw 20 sets of patient medical records and saw they included pre admission and pre-operative assessments that took into account individual patient preferences.
- The service involved patients' relatives and people close to them in their care. They told us they received full explanations of all procedures and the care they would need following their operation.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place. This also reflected patient centred care and that patients' individual needs were taken into consideration.
- We saw cards and leaflets on the wards with information for patients on how to leave feedback. In addition, the hospital's website had the facility for patients to leave feedback.
- We saw staff introduce themselves to patients, explain their role and the examination that was about to be performed.
- We saw that when staff were in a patient's room they pushed a button, which illuminated a light on the ceiling outside the room. This meant staff knew when patients were receiving care and did not enter the room, protecting their privacy and dignity.

Emotional support

- The hospital used the Butterfly scheme in its wards and departments. This scheme supports patients with dementia and memory impairment. It aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment. Butterfly symbols were put by the patient's bed and reminded staff to follow a special response plan.
- There was information displayed regarding a variety of support groups for example smoking cessation, alcohol misuse and counselling services.

Good

Surgery

- There was multi faith chaplaincy support available at the weekends when chaplains visited patients on the ward.
- Patients told us they felt able to approach staff if they felt they needed any aspect of support.
- Staff had access to specialist nurses at a NHS hospital if required by patients, for example stoma care specialist nurse.
- All patients received a follow up phone call 48 hours after they were discharged, which meant patients had the opportunity to discuss any concerns or worries they may have.
- The hospital undertook a patient satisfaction survey in quarter two 2016 (01 April- 30 June).This showed that 97% of patients found someone to talk to at the hospital about concerns or worries.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet local needs. The hospital identified there was local patient demand for the treatment of patients suffering with infections for example, chest infections. This was a service that the hospital provided which met the needs of local people.
- The hospital worked with the local Clinical Commissioning Groups (CCG's) in planning services for NHS patients. The unit provided elective surgery to NHS patients for a variety of specialities, which included orthopaedics, gynaecology and general surgery. This meant local people had a choice about where they received their care and treatment.
- All admissions for surgery were elective procedures therefore service planning was straightforward as the workload was foreseeable.
- Patients arrived at different times to enable staff to manage admissions and to reduce the waiting times for patients.
- The hospital had recently invested in a significant modernisation programme, which upgraded the facilities to meet the needs of the patients who used them. The hospital had modern facilities designed to suit the services offered. The ambulatory care pods were designed for a fast throughput of patients and could be easily and quickly cleaned.
- There was a specific endoscopy (a test that looks at the inside of the body) unit with its own recovery and purpose built patient pods designed to meet the needs of patients undergoing endoscopy procedures.
- The senior staff in theatres reviewed operating lists in advance. This ensured there was sufficient time to arrange all the necessary staff and equipment.
- The patient rooms on the ward had been designed to look non-clinical and more like a bedroom. For example, the oxygen outlets and plug sockets were concealed from view.

Access and flow

- Medical patients could be admitted to the ward via a clinic appointment with a consultant or directly to the ward.
- The NHS patients were referred to the hospital via their general practitioner (GP), via the 'choose and book' system.
- Discharge arrangements were considered and acted upon from pre-assessment and thereafter throughout the patient journey, facilitated by the multi-disciplinary team (MDT). We saw the MDT actively engaged in the discharge process, for example in ensuring patients could; mobilise safely, understood their post-operative exercises and had provision for aftercare when returning to the community or their own home and equipment was required.
- When patients undergoing a procedure or operation arrived at the hospital they booked in at the main hospital reception and the reception staff informed the relevant department of their arrival. When the ward staff were ready to admit the patient they were collected from the reception and taken to the endoscopy

department, day surgery ward, ambulatory pod or the ward. Pre- admission checks and assessments were undertaken, and when complete, the patient changed and waited for their procedure. Staff then escorted patients to the theatre or endoscopy room for their procedures. The majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room either in theatres or the endoscopy suite.

- Once patients were stable and pain-free, staff took them back to the ward area or room to continue recovering. Patients who were a day case had a responsible adult to collect, escort and stay with them for 24 hours. We saw in the patient's care plan there was a section that must be completed with the nominated adult's name and contact details. This ensured staff were aware who to contact when the patient was fit for discharge and who would stay with them for 24 hours. Patients who were not a day case stayed overnight or for a series of nights until ready for discharge.
- During our inspection, the theatre lists ran on time and we saw staff kept patients informed of their approximate procedure time. The inspection did not highlight any concerns relating to the admission, transfer, or discharge of patients from the ward, departments or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times, or discharge arrangements.
- Theatre staff had an on call rota arrangement to manage any unexpected returns to theatre including weekends and overnight. This meant staff were available to ensure patients had timely access to services. Staff told us it was very rare that they would be called in.
- The provider reported 42 cancelled procedures for a non-clinical reason between July 2015 and June 2016.In the last 12 of these, 100% were offered another appointment within 28 days of the cancelled appointment.
- The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. NHS England stopped the national target in June 2015. However, the hospital continued to treat the majority of its inpatients within 18 weeks of referral.
- RTT for NHS-funded patients having inpatient surgery at the hospital within 18 weeks of referral was on average, above 90%. . This was equal to or above the national target of 90%.
- RTT was monitored via the weekly elective wait monitoring report, which was circulated by corporate Ramsay Health Care UK.
- Visiting times on the ward were between 9am and 1:30pm and 3:30pm and 9pm, and there was a rest period for patients between 1:30pm and 3:30pm.This meant patients had a protected time to rest.
- The booking office booked patients onto operating lists or endoscopy lists and the admissions for the next day were reviewed at a multidisciplinary meeting daily at 11am.The meeting included ward staff and theatre staff. This ensured the availability of beds and theatre capacity was confirmed.
- In the office on the ward, there was a patient information board, which used visual symbols to indicate where the patient was in their journey. For example, a "T" meant the patient was in theatre, and this meant it was easy to identify where patients were.

Meeting people's individual needs

- Pre-assessment was used effectively to ensure the hospital only treated patients if they could meet their needs.
- Staff confirmed patients identified as high risk, such as diabetic patients, were usually scheduled for surgery at the beginning of the theatre list in case they developed complications during their procedure. This was communicated via the pre assessment staff and highlighted on the printed operating list/endoscopy list.
- Staff told us that patients living with learning difficulties or additional needs were highlighted at the pre assessment stage. The purpose of this was to alert clinical staff to the patient's individual needs. This allowed staff to plan effectively, for example by arranging theatre lists in a way that lessened anxiety for patients living with learning disabilities.

Good

Surgery

- The inpatient department used a 'yellow blanket' program where patients living with dementia, increased fall risks and other needs had a yellow blanket to alert staff. In addition, a yellow symbol was put on the outside of a patient's room door to alert staff.
- Patients that had been assessed as a high risk of having a fall had a "stop" notice put on the inside of their door which acted as a prompt for them to stop and not go out of the door. In addition, patients at risk of having a fall could have a sensor monitor mat on their bed. This alerted staff when the patient had got out of bed and was at risk of having a fall.
- There were telephones available with larger buttons for patients who were visually impaired or unable to use small buttons. This meant this group of patients were able to communicate with friends and family.
- Physiotherapists reviewed patients individually pre operatively, which ensured if any special equipment was required for the patient this could be arranged in advance. For example, for a patient who was visually impaired arrangements were made for them to have access to a special machine, which enlarged the instructions of physiotherapy exercises.
- There were wheelchairs and lifts available for patients who needed assistance because they were less mobile.
- Staff told us the hospital could book interpreters for patients. Patient information leaflets could be printed from a database in different languages.
- For patients with hearing loss, a hearing loop was provided in the main reception of the hospital.
- We were told that should a patient require the support of a carer or a family member they were encouraged to stay at the hospital to offer familiar assurances.
- There were walk in showers available for patients unable to use a normal shower because of mobility problems.
- The most recent Patient Led Assessment of the Care Environment (PLACE) survey showed the hospital scored 77% for dementia, which was worse than the England average of 80%. However this did not reflect our findings in relation to care provided for patients living with dementia.
- Patients with specialist dietary requirements were highlighted at pre- assessment and the catering staff informed.
- Catering staff had reference folders, which contained specialist diet instructions such as high fibre diets, low potassium and gluten free which the catering staff used to ensure compliance.
- The hospital's chef had undertaken additional training in nutritional and dietary requirements. The chef said he was able to cater for specialist diets including diets in relation to religious beliefs.

Learning from complaints and concerns

- The hospital received 79 complaints between July 2015 to June 2016. Of these, none were referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service). The hospital did not provide a breakdown of complaints by ward or department.
- The number of complaints was above the rate of other independent acute hospitals; however, we were told this was because of the way that the hospital recorded complaints, as even positive feedback falls into the same category.
- Three themes and trends had been identified within these complaints; administration communication, financial, and clinical care.
- In the Ramsay Hospitals Health Care UK, the general manager had overall responsibility for the management of complaints although other senior staff may be involved in the investigation and resolution.
- Complaints were also handled by the general manager's personal assistant (PA) and the matron's PA who led on co-ordinating and managing complaints. The training that they had received to take on this role was minimal with one staff member having had no formal complaint management training. This meant they might not have the skills and knowledge required for dealing with complaints.
- Complaints were acknowledged within two working days via phone or e-mail and then a response was provided within 20 working days and logged onto the electronic reporting system within the hospital. As part of the complaints process, all complainants were given a direct telephone number for the management team for further feedback or queries.

Good

Surgery

- If this timescale was not possible, for example because further information was required, a holding letter was sent to the complainant so that they were aware their complaint had not been forgotten and was still being looked into.
- When a complaint was logged, the head of the relevant department was informed and took the lead on the investigation, statement collection, and any actions. This meant that complaints were handled and learnt from by the department it was relevant to.
- All staff involved in a complaint could access its progress through the electronic reporting system. Statements were uploaded directly to the system. Timescales were managed from here with a reminder being sent to staff members who had not responded in a timely way.
- Meetings with patients and relatives were arranged if needed. We were told that this approach was the preferred method as it provided a quicker resolution and allowed a conversation to understand the complaint more fully.
- Complaints were a standard agenda item on the clinical governance committee meetings and heads of department meetings, and we saw the minutes of these meetings to confirm this.
- There were mechanisms in place for shared learning from complaints through the staff meetings, team briefings and safety briefings. We heard of examples where changes in practice had occurred following complaints for example a recent change in menu options
- We also heard of a trend for self-funded patients not realising the cost of multiple blood tests, and as a result, we saw documented evidence that this had been raised in departmental meetings and staff were told to make sure patients fully understood the costs of blood tests before they were undertaken.
- The complaints process was outlined in information leaflets, which were available on the ward areas and individual patient rooms.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The overall lead for the service was the general manager, who was supported by the matron, finance manager, operations manager and senior human resources manager. Clinical services were led by the matron who was supported by: the theatre manager, pharmacy manager, physiotherapy manager, ward manager, quality improvement lead, sterile services manager, imaging manager and outpatient manager.
- We saw leaders valued and respected staff. Staff felt valued and told us that leaders were visible and approachable.All staff told us the managers were highly visible throughout the hospital, often undertaking walk arounds to all areas. Staff told us they felt supported by their managers and colleagues.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.
- Staff said they generally received information regarding incidents and were involved in making changes as a result of incident investigations. Staff understood and felt involved governance processes.
- Staff told us they enjoyed their jobs, were proud of the hospital and of the treatment and care they provided to patients.
- There was a flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed between the multidisciplinary teams.
- The Ramsay Health Care UK 2016 staff survey showed that 81% of staff at Ashtead hospital felt their line manager gave them the support required to do their job well.
- In the same survey 99% of staff said they always worked with the best interests of the patients and their colleagues.

Vision and strategy for this this core service

- The provider had a clearly defined set of corporate values identified as 'The Ramsay Way'. This was reflected

throughout corporate literature and on signage throughout the hospital. Staff demonstrated an understanding of 'The Ramsay Way' and this was reflected in their work.

- The hospital vision was to become, 'a leading provider of healthcare services in Surrey by delivering high quality outcomes for patients and ensuring long term, sustainable profitability.'
- The hospital had 2016 clinical and business strategies to meet the vision of being a leading healthcare provider in the area. The Ashtead hospital vision and business strategy plan 2016 reflected that it had identified growth potential through contracts with local Clinical Commissioning Groups (CCG) and promoting its services to GP practices in other local CCG areas. They had identified areas for growth of specific specialties and were working to raise the profile of consultants in these areas.
- The Ashtead Hospital Clinical Strategy 2016 outlined plans to engage clinical staff in developing and owning clinical strategy, promote safeguarding, promote and sustain staffing levels and improve patient experience. This document reflected steps had been taken to meet these goals. Clinical teams had submitted their departmental visions and ideas, which were progressed, actions had been taken towards promoting safeguarding and recruitment was ongoing.
- Throughout our interviews, staff repeated the vision to be the leading provider in Surrey or even in the country and reflected that they understood their part in meeting the goals. This meant that the staff had understood this vision and were committed to achieving it.
- The Ramsay Health Care UK 2016 staff survey showed that 76% of staff at Ashtead hospital understood how the 'Ramsay Way' guides how they work.

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

- All policies used by Ashtead Hospital were Ramsay Health Care UK Corporate Policies, which provided continuity of practice. The corporate policies referenced national guidance and were in date and regularly reviewed.
- There was a governance framework to support the delivery of the operations, strategy and care. This was made up of the Heads of Department (HODs) and several risk and governance groups (clinical governance, infection control, health and safety) that fed into the medical advisory committee (MAC). The MAC met four to five times a year and included representatives from all specialities including medicine.
- A senior manager explained that HODs had formal meetings monthly and HOD huddles three times weekly. The HOD huddles focused on current issues. The general manager attended the monthly meetings, which were more formalised and often discussed matters raised in the HOD huddles.
- The group structure meant that there was duplication between these meetings. For example, the matron told us that a never event would be discussed at the HODs meeting, HODs huddle, clinical governance meeting, MAC and quality group. However, the matron explained that this ensured information reached everyone.
- The MAC was responsible for overall governance of the hospital although in practice they delegated the lower level decision making to the management team. Management reviewed complaints and incidents but the MAC reviewed issues that were more serious.
- The hospital had a risk register; however, the risk scoring system was unclear. There were high, medium and low levels of risk on the risk register, but it was not clear how these correlated to the electronically assigned risk scores on the incident reporting system. When we asked, senior members of management were not able to explain the relationship between the risk scoring systems.
- We asked managers regarding the top risks within the hospital, and they listed clinical risks such as falls and sharps injuries in addition to operational risks such as the estate of the hospital. Clinical risks however were not included on the risk register, which meant the risks might not have been assessed and steps taken to mitigate the risks.
- Items on the risk register had actions to mitigate the risk. However, these actions were not SMART (specific, measurable, achievable, relevant, time specific), were not assigned to specific action owners and lacked a timescale. This meant that no named individual that

was taking responsibility for the actions or verifying that they were completed. When we asked a manager regarding this, we were advised that HODs managed these.

- We undertook a review of three root cause analysis (RCA), these showed a variable level of detail. We raised this with a manager who said managers were in the process of undertaking RCA training.
- We saw from meeting minutes that risks were discussed at several meetings, however the minutes did not show how these were managed and actioned.
- Information discussed at the MAC and HOD meetings was cascaded to staff at team meetings and via communication folders. We saw that the notes were in the departments and staff signed to say that they had read them.
- Practising Privileges were granted in accordance with the Ramsay Facility Rules. The applicant would first meet with the hospital's General Manager and, subject to suitability and availability, the application process was commenced. The application form and supporting documents were submitted to the General Manager's personal assistant (PA).Once processed the application was sent to the medical advisory committee (MAC) representative for that speciality for initial clearance, then to the hospital credentialing committee and MAC with final approval granted by the Ramsay Medical Director in accordance with the Ramsay Corporate credentialing committee. To support the application documents were completed; the Disclosure and Barring Service (DBS) current CV, medical indemnity insurance, General Medical Council (GMC) registration, appraisal, speciality certification ,immediate life support (ILS), training certificate, log book and mandatory training. These documents were reviewed and maintained by the General Manager's PA and uploaded on the Ramsay Healthcare credentialing database. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- Revalidation of consultants was part of the annual appraisal conducted by the consultant's employing NHS trust, appointed appraiser by Ramsay Healthcare, or approved Responsible Officer (RO) if the consultant only practices privately. All consultants provided documented evidence of their appraisal, this was recorded on the Ramsay Healthcare credentialing database, and a hard copy held on their file.
- The hospital had a clinical audit program, which included audits of medical records, consent, preadmission and discharge, care pathways and variance tracking, controlled drugs, prescribing, medicines management, radiology referral forms, radiology, and post exam, radiology, radiology MRI and CT, physiotherapy, theatre and infection prevention and control.
- Staff told us they had access to policies and procedures and felt they were kept up to date and informed by managers.
- The Ramsay Health Care UK 2016 staff survey showed that 95% of staff at Ashtead hospital knew how to deal with safety issues in the areas that they worked.

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

- The hospital had introduced quality and customer services staff groups. The function of these groups was to identify areas where patient care could be improved. The groups were made up of volunteer staff members from a variety of departments and staff grades throughout the hospital. Staff members who attended the groups told us that they thought that the groups were valuable and they took pride in their involvement.
- The hospital gathered patient opinion using patient surveys offered to all patients during their stay, friends and family test (FFT) and patient led assessment of the care environment (PLACE) which was carried out annually.
- There were various staff recognition schemes, including service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years.
- The provider produced monthly newsletters and regular clinician bulletins to engage with staff and communicate developments within the organisation.

Good

Surgery

- We saw noticeboards displaying information around the hospital to inform staff on a variety of subjects for example infection prevention and control, health and safety, safeguarding and lessons learned from incidents and complaints.
- The Ramsay Health Care UK 2016 staff survey showed that 78% of staff at Ashtead hospital felt they were a valued member of the team where they worked.

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

- Increased funding had been allocated to allow staff to undertake more external training and development to improve the quality of care given to patients and to encourage staff to stay working at the hospital. For example, the theatre manager was undertaking a Master of Science degree and was looking at the effect of hypothermia (decreased body temperature).
- A practice development nurse was employed to support new members of staff and provided additional support and guidance for staff.

Requires improvement

Services for children and young people

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

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- The hospital used an electronic reporting system that provided reports to allow analysis of incidents, complaints and health surveillance data. The system also provided the matrons with incident benchmarking reports known as funnel graphs. These graphs plotted incident rates for all categories of incidents and included data from all Ramsay Group hospitals. This enabled the identification of units that were outliers in a particular area.All 'outliers' were reviewed by the corporate Clinical Governance Committee and the relevant site is contacted and asked to provide an explanation.'
- Staff in physiotherapy told us that the electronic incident reporting system used in the hospital was easy to use although, to the point of the inspection, there had not been any incidents reported that involved children or young people.
- The paediatric lead nurse told us that to their knowledge there had never been a clinical incident relating to a child that had been reported on the incident reporting system.
- The Ashtead hospital ensured patients were made aware of events when things went wrong via their duty of candour policy. A robust investigation would be completed with the relevant staff involved. We asked staff about the duty of candour and, whilst staff were aware of their obligations and had knowledge and understanding, they had not had cause to refer to the policy.

Cleanliness, infection control and hygiene

- Data regarding incidents of meticillin resistant staphylococcus aureus (MRSA) or Meticillin sensitive staphylococcus aureus (MSSA) E-Coli and clostridium difficile (C.diff) in the reporting period (July 2015 to June 2016) are reported in the surgery section of this report.
- Clinical areas we observed during the inspection, including the gymnasium in physiotherapy appeared clean. There were sufficient hand sanitisers available across the hospital.
- Full details regarding the cleanliness of the outpatient areas can be found in the outpatient and diagnostic imaging section of this report.

Environment and equipment

- All plant, equipment and the building underwent scheduled testing. A range of internal and external health and safety inspections and audits were carried out on a scheduled basis. There was an inventory of equipment and an equipment replacement programme with capital funds available to fund replacements. Equipment service records were maintained.Equipment was on the Provision and Use of Work Equipment Regulations (PUWER) register and all staff were trained to be competent in its use.
- There was a paediatric resuscitation trolley positioned prominently in the outpatients department. This was equipped with all the appropriate paediatric

equipment. A registered nurse carried out checks on the resuscitation trolley. The checks carried out included a daily check to ensure all equipment was available. There was also a weekly check that required all of the drawers to be opened and equipment checked to ensure nothing had passed its expiry date. All expiry dates were recorded, as were the dates of the equipment checks. Once a month the trolley was cleaned and fully checked. Records of all the checks carried out were kept on the resuscitation trolley.

- There were resuscitation trolleys located throughout the hospital. Checks on these trolleys showed that they were equipped with kit suitable for use on children and young people including paediatric automated external defibrillator (AED) pads and gel masks. However, the list of drugs stored on the trolleys located away from the outpatient area did not contain any drugs that were specifically for children and young people. This meant that in the event of an emergency involving a child or young person outside the outpatients department, there might not be appropriate drugs immediately available.
- The pharmacy team took responsibility for ensuring the paediatric arrest box was filled with drugs appropriate for children and young people. This meant that the team filling the paediatric arrest box had not completed the drug list that was kept on the resuscitation trolley.
- Full details of the findings regarding the environment and equipment can be found in the outpatient and diagnostic imaging section of this report.

Medicines

- As children and young people attending Ashtead Hospital would predominantly be attending for outpatient appointments, detailed findings on the use and storage of medicines can be found in the safe section of the outpatient and diagnostic imaging section of this report.

Records

- The hospital used the Ramsay Healthcare UK Clinical Record Keeping Policy, which was in date and due for review March 2017. The policy stated that the minimum data set for outpatient records should include a GP referral letter, consultant outpatient notes taken during the appointment and additional requirements according to treatment plan. The consultation record should include the reason for consult, examination record, chaperone record, risks/benefits/alternative treatments discussed, diagnostics requested, agreed treatment plan, reason for ongoing referral or referral back to GP.
- At the time of the inspection, the filing and retention of records on site for children and young people attending outpatient appointments had only been happening for approximately eight weeks. We reviewed ten sets of these records during the inspection. The records we reviewed contained little information other than a carbon paper copy of some basic details of the patient and the consultant. There was no record reflecting the content of the consultation. This meant that should a parent need to call the hospital for advice, there would be no record for any of the staff to access and assist. Instead, parents would have to contact the consultant directly through their secretary.
- Records for children and young people attending physiotherapy appointments were kept in full on site until the course of treatment has been completed.
- At the time of the inspection, the hospital was in the process of developing an electronic records system. However, all staff we spoke with about this told us that the project had been postponed on a number of occasions and that there was no definitive 'go live' date. It was anticipated by the staff that there would be no transfer of paper records to the new system but all new patient records would be kept on the electronic system.

Safeguarding

- Ashtead Hospital had a children's safeguarding lead that had been trained to level four in children's safeguarding. However, the safeguarding lead did not work directly with children. All the safeguarding information relating to children and young people, including a file with escalation and reporting protocols, was kept in an area where children would rarely go.
- We were told by the safeguarding lead that there had only been one incident that had been recorded as a child safeguarding incident in at least the last nine years.
- In addition to the safeguarding children's lead nurse, it was planned the paediatric lead nurse would share the

role of safeguarding children's lead. This meant that the paediatric lead nurse would have an enhanced role in children's safeguarding. It was anticipated that this would happen in January 2017, as part of the safeguarding action plan, when the hospital's safeguarding group was scheduled to have its first meeting.

- We were provided with the paediatric safeguarding action plan. This showed the plans in place to improve the hospital's safeguarding provision. It clearly identified who was responsible for what actions and a timeframe in which the actions would be completed.
- The hospital had a local safeguarding register to log all concerns, which were reviewed by matron and the matron then decided to contact the appropriate community safeguarding team. All staff we spoke with specifically about child safeguarding and who were involved in providing safeguarding training and the safeguarding leads spoke of strong links with the local safeguarding children's board. This was demonstrated by the fact that the local authorities' child safeguarding team provided the face-to-face element of level three safeguarding training. We were told that staff required to be trained to level three either had had, or were scheduled to have face-to-face training with the local authority.
- Consultants with practising privileges, as part of their contract had to demonstrate that they had been trained to level three in children's safeguarding.
- All physiotherapists and staff within the physiotherapy department were compliant with the hospital's mandatory safeguarding children training. The physiotherapists we spoke with were confident that they would be able to recognise any safeguarding issues and knew the correct pathways to raise any concerns. We saw the safeguarding reporting protocol, which was displayed prominently in the physiotherapy office.
- Although the hospital had a child safeguarding lead, we were told that they were not involved in any of the children's safeguarding training provided to other staff. This meant that the knowledge of the safeguarding lead was not being shared with other staff and opportunities to increase awareness of child safeguarding issues were being missed.
- We saw that the hospital had a leaflet available for patients in the hospital's waiting areas entitled 'keeping people safe from abuse'. This helped people identify the different form of abuse that might occur as well as guidance on how to report it.

Mandatory training

- All Ashtead staff completed safeguarding competencies as part of their mandatory training. They also had a paediatric and adult safeguarding champion.
- There was a total of 157 clinical staff of which 152 had undertaken paediatric basic life support (PBLS) training or paediatric immediate life support (PILS).Clinical staff that had not yet undertaken the training had courses scheduled at the end of 2016 and beginning of 2017.
- At the time of the inspection, compliance with the mandatory safeguarding training was low. The hospital had a target of 90% of staff to have completed mandatory training. Level one training had been completed by 76% of the 280 staff required to undertake this training. Level two training had been completed by 96% of the 150 staff that were required to complete it. Online level three training had been completed by 85% of the 34 staff required to do it although a number of these staff had yet to complete the face to face element of the training. Three dates had been agreed with the local authority, early in 2017 for staff to attend the face to face element of the children's safeguarding training.
- Full details of compliance with mandatory training are reported in the outpatients section of this report.

Nursing staffing

- We were told by that the paediatric lead nurse that they would be available and on duty when paediatric patients were seen in the outpatient department, diagnostic imaging or physiotherapy departments. However, staff in the physiotherapy department told us that that arrangement had been relaxed and that they did see patients when the paediatric lead nurse was not on duty. The children and young people seen in physiotherapy would be aged over 16.
- The hospital used an electronic staffing roster system to ensure there was a safe skill mix with a senior nurse on each shift.

Requires improvement

Services for children and young people

- The hospital had a paediatric lead nurse who was available two days a week to support consultants in their outpatient clinics and to assist with minor procedures, such as lingual frenotomy (lingual frenotomy when appropriate.
- Full details of nursing staffing are reported in the outpatients and diagnostic imaging section of this report.

Medical staffing

- At the time of the inspection, there were nine consultants with practising privileges that worked with children and young people. The consultants covered a range of specialties including, but not limited to ear, nose and throat, orthopaedics, dermatology and general paediatrics.
- The hospital had a named consultant for paediatric support. This gave the hospital senior support for any paediatric matters. The named consultant specialised in paediatric gastroenterology and worked in the local NHS Trust.
- The resident medical officer (RMO) was on site 24 hours a day and was trained to European Paediatric Life Support (EPLS) level.
- When a new RMO was cleared to work at Ashtead Hospital the RMO agency forwarded the RMO's CV to the hospital matron with details of all up to date training they had completed / attended including paediatric basic life support (PBLS) and paediatric immediate life support. The RMO's CV and training evidence was reviewed by the Chair of the hospital Medical Advisory Committee (MAC) before being cleared to work. Any RMO's that worked at Ashtead Hospital for an extended period of time were invited to attend the hospital in-house training or complete corporate e-learning, if they were unable to produce evidence of having undertaken mandatory training as part of their appraisal requirements with their employment agency.
- Practising Privileges were granted in accordance with the Ramsay Facility Rules. The applicant would first meet with the hospital's General Manager and, subject to suitability and availability, the application process would be commenced. Once collated the application was sent to the MAC representative for that speciality for initial clearance, then to the hospital Corporate Credentialing Committee (CCC) and MAC with final approval being granted by the Ramsay Medical Director in accordance with the Ramsay CCC. Applicants must have completed a Ramsay Disclosure and Barring Service check and submit a current CV, proof of medical indemnity insurance, GMC registration, appraisal, speciality certification, Immediate Life Support (ILS) training certificate, log book and mandatory training. These documents were reviewed and maintained and uploaded on the Ramsay Healthcare credentialing database.
- Revalidation formed part of the annual appraisal conducted by the consultants' employing NHS Trust. If they undertook wholly private practice, Ramsay Healthcare would appoint an appraiser. All Consultants provided documented evidence of their appraisal, this was recorded on the credentialing database, and a hard copy was held on their file.

Emergency awareness and training

- The hospital had plans and strategies to respond to emergency situations and to ensure appropriate action is taken should any incidents arise. A Resident Medical Officer (RMO) provided 24-hour medical and surgical cover for all patients.
- Should there be an emergency with any child attending the hospital the protocol would be to call an ambulance to take the child to the local NHS Hospital.
- The hospital used the WETFLAG emergency paediatric assessment tool. WETFLAG is an acronym for Weight, Energy, Tube Age, Fluids, Adrenaline and Glucose. This allowed nursing staff to record results that helped decide what further treatment should be provided.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- The hospital participated in relevant local and national audits, including clinical audits and other monitoring such as benchmarking and service accreditation for

diagnostic imaging. However, at the time of the inspection the hospital did not undertake clinical audits in the outpatient area. This meant that there were no local paediatric clinical audits carried out.

- National Institute for Health and Care Excellence (NICE) guidelines and local policies and procedures were discussed at clinical meetings and through the hospital Medical Advisory Committee, with a log of all appropriate NICE guideline compliance reviewed at each meeting.

Pain relief

- As children were no longer treated in the inpatient department, the need for pain relief had reduced. However, children who attended the hospital for venepuncture or required cannulation would be offered anaesthetic creams or cryogesic spray to numb the area. A record was kept of the application, which included the patient's details, the consultant details, a note of the discussion with the parent or carer, the topical anaesthetic used and the dose administered.

Nutrition and hydration

- Children attending Ashtead Hospital were rarely in the hospital for a period of time that would require them to need meals. This was because they only attended for outpatient appointments and would not attend as inpatients. There was water freely available in waiting areas as well as facilities to get other drinks if necessary.

Patient outcomes

- The hospital did not see any children or young people that were NHS patients. This meant that they did not have nor were required to keep any data to provide to national NHS audits. At the time of the inspection, the hospital did not undertake any outpatient or paediatric audits. It was therefore not possible to assess patient outcomes by any means other than the patient's feedback. Audits regarding patient outcomes in diagnostic imaging are reported in the outpatients and diagnostic imaging section of this report.

Competent staff

- The physiotherapy team had devised a competence audit tool for physiotherapists treating paediatric patients. The audit included elements such as whether the member of staff had received child safeguarding training at level three, paediatric immediate life support training and whether staff treated children age appropriately. The audit tool consisted of a table that demonstrated which member of staff had achieved the required level of competence.The information collected for use in the competence tool was gained through staff attending formal courses and through peer review of their performance in the clinical environment.
- Staff we spoke with said that there was no issue accessing training that was relevant to their role. They told us that the hospital and wider Ramsay Group encouraged and supported staff in their development.
- Systems and policies were in place to ensure staff were competent including recruitment, induction, training and development programmes, performance and development review (PDR), clinical supervision, performance improvement processes and revalidation.
- As there was only one paediatric nurse employed at the hospital, staff appraisal rates are reported in the outpatient and diagnostic imaging section of this report. The paediatric lead nurse told us that they had had their annual appraisal.

Multidisciplinary working

- Although the hospital held daily multi-disciplinary team meetings to review activity and staffing levelsand fortnightly Clinical Head of Department meetings to discuss patient issues, there were no specific MDT meetings to review the care of children and young people.
- The Ashtead Hospital provided services for children and young people for appointments with consultants in a range of specialties as well as for physiotherapy appointments and diagnostic imaging. We spoke with staff in physiotherapy who explained how they wanted to develop their relationship with the consultants. Although they had been working together, the team had realised that there were mutual benefits to be gained by working much more closely. During the week of the inspection there was a meeting planned between the physiotherapy team, the paediatric lead nurse and the orthopaedic consultants. However, there was no formal arrangement for this to happen regularly, nor was there any cross-hospital group for staff to discuss matters relating to children and young people.

Requires improvement

Services for children and young people

- The paediatric lead nurse told us about how they had developed their relationship with the infection prevention and control team at a specialist NHS children's hospital. The paediatric lead nurse had a named contact as part of the relationship. This had provided a source of advice with any issues that arose at the hospital relating to infection prevention and control.
- We spoke with the pharmacy team who explained how they had little interaction with paediatric patients or consultants. However, they did on occasion work with dermatology consultants, particularly those treating patients with acne.

Access to information

- We observed signs around the waiting areas in the hospital informing those attending an appointment that there was a chaperoning policy for children in place. Staff we spoke with were aware of the chaperoning policy and knew where they could find it. A nurse showed us the chaperoning policy that was in the Ramsay 'Care of Child' Policy.This was kept in a paper copy in the department/ electronic form which was available to staff.
- We were shown a folder kept in the outpatients' department office, which contained a wide range of information regarding children and young people including safeguarding, Royal College of Nursing competencies, information about paediatric transfers from Ashtead Hospital to local and specialist NHS hospitals. There was also information about consent and Gillick Competencies (Gillick Competence. All of this information was available to staff online.
- One parent we spoke with during the inspection explained how they had been able to find a suitable consultant to see their child through searching the hospital's website pages. They told us how they had been able to get all of the information they needed from both the website and the staff they contacted when looking to make an appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed one young child patient being verbally consented by the paediatric lead nurse through their parent when attending an appointment. Details of what they were being asked to consent to were clearly explained by the paediatric lead nurse.
- Mental Capacity Act (MCA) training and Deprivation of Liberty Standards (DoLS) training were both part of the mandatory training programme. Staff we spoke with had a good understanding of both MCA and DoLS.
- We were told that on rare occasions, staff dealing with children and young people had had cause to use restraint. If this were necessary, it would be done in accordance with the Royal College of Nursing Guidelines on restraint and would only ever be done if it were in the patient's best interests. There had been no reports of this having happened during the reporting period.

Are services for children and young people caring?

Not sufficient evidence to rate

We did not rate the caring domain due to insufficient evidence.

Compassionate care

- Staff told us that it was their aim to ensure that patients that had attended for a blood test leave with a smile on their face. They were given a bravery sticker and a small bag of sweets before leaving the hospital.
- We observed an appointment where a young baby had a bilirubin test. Staff gave the parent a clear explanation of what was going to happen. The explanation was appropriate and the member of staff made good eye contact with the parent and was able to put the parent at ease.

Understanding and involvement of patients and those close to them

- We spoke with the parents of two patients who were attending the hospital during the inspection. Both were complimentary about the care both they and their child had received. One parent was keen to emphasise how pleased they were with the care and empathy that had been shown to them by all staff.

Requires improvement

Services for children and young people

- We saw that there were cards placed around the waiting areas. These were called well done and thank you cards and were easily available for people to take. This gave patients the chance to provide feedback following their appointment.

Emotional support

- The parents that attended with the child provided most of the emotional support. There were no specific services offered by the hospital in this regard. However, the interactions we did observe between all staff and children and parents or carers were warm and had the thoughts and feelings of the child and parents or carers at heart.

Are services for children and young people responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Ashtead Hospital took the decision in August 2016 not to offer inpatient care to children and young people. They did however carry out blood tests and some minor procedures under local anaesthetic. They did not do any work with lasers or any ear, nose and throat procedures although they did carry out lingual frenotomy. The hospital did not do any endoscopic work with children and young people.
- Children from the age of 0-17 were seen in the outpatient department. There was a dedicated waiting area for younger children, which included a play area. At the time of the inspection, there were just a few building blocks and one piece of play kitchen equipment for the children to play with when waiting for their appointment. However, during the inspection, new toys were bought although most of them could not be used due to infection control risks. The decision to remove the new toys was taken following consultation with an infection prevention and control specialist at an NHS hospital.
- The physiotherapy department saw children with musculoskeletal and orthopaedic conditions. A detailed assessment was carried out with a parent or guardian present throughout. All physiotherapists and staff within the department were compliant with the hospital's mandatory safeguarding children training. All physiotherapists were vigilant in looking for any safeguarding issues and knew the correct pathways to raise any concerns. We were shown the safeguarding reporting protocol, which was displayed prominently in the physiotherapy office.
- The hospital did not perform computerised tomography (CT) scans, electroencephalogram (EEG) or electrocardiogram (ECG) on children and young people. They did perform plain film x-rays and magnetic resonance imaging (MRI) scans.

Access and flow

- Ashtead Hospital did not carry out any NHS work on children and young people so the patients were all insured or self-paying.
- There were 3100 outpatient attendances between July 2015 and June 2016 for children and young people aged zero to 17 years old; 274 patients aged zero to two, 2226 aged three to 15 and 600 aged 16 and 17.
- Children over the age of three years were seen as outpatients within the Diagnostic Imaging department. A specialist paediatric consultant radiologist who undertook paediatric work as part of their NHS practice completed all ultrasound investigations and plain film reports.
- The physiotherapy service ran five days per week between 8am and 8pm. The service was also available on a Saturday between the hours of 8am and 12pm or 8am and 2pm, depending on staff availability.

Meeting people's individual needs

- When ultrasound procedures involved cannulation for MRI, the patients were booked at a time when the paediatric nurse specialist was available at the hospital to support the patient and their family through the procedure.
- Appropriate communication skills were used to allow children of varying ages to be involved in their care. This included the use of paediatric pain score charts as

appropriate. The pain score chart contained pictures, numbers and words. An adapted consent form was also used before the first assessment. We saw evidence of both of these during the inspection.

- In the physiotherapy department, treatment plans were developed with the child and parent or guardian and a parent or guardian would be present for all treatment sessions. Children were treated in individual treatment rooms or in the gymnasium. Treatment given would depend on the specific condition but included exercises, postural work, manual therapy and soft tissue techniques.
- Reception staff in the physiotherapy department had an awareness of the areas of special interest for all of the physiotherapists and knew which physiotherapists could work with children and young people. This meant that children and young people would have appointments booked with a physiotherapist that was most able to treat them.
- The physiotherapy team had a contract with a local swimming pool that allowed them to use the pool for hydrotherapy. Some of the young people that they had seen had accessed this service and we were told that they had received positive feedback and it was deemed a success in treating those patients.
- An annual risk assessment was carried out for treating paediatric patients within the department and all physiotherapists treating children were assessed on paediatric competencies as well as undertaking yearly paediatric immediate life support (PILS) training. The hospital had a designated paediatric lead physiotherapist. The physiotherapy department provided members of the team with a paediatric update on any issues and included paediatric specific subjects in their in service training (IST) programme.
- Should there be difficulty in taking blood from a child staff would allow a child or young person to sit where they were comfortable.
- Any child aged three or younger would have blood taken by either the paediatric lead nurse or the consultant paediatrician if available. Any child over three would have blood taken by a registered nurse unless they were frightened or anxious in which case the paediatric lead nurse would carry out the procedure.
- If a child under three required blood to be taken and the paediatric lead nurse was not available, the child would be referred to the local NHS hospital for this to be carried out.
- The hospital did provide children with access to crayons and colouring pads although they were not readily available and were kept in a cupboard. We did not see any children making use of these during our inspection.
- Nursing staff, when dealing with children would be able, if necessary, to change into a child friendly tabard (this was a tabard with children's characters on it, rather than a tabard that looked clinical) in order to put to the child at ease. The decision to wear this would depend largely on the age of the child.
- We were told that although the physiotherapy department had not had any patients that were not able to speak English, they did have the facility to use telephone interpreters if need be. Telephone interpreters were also available should they be needed for any outpatient appointments.

Learning from complaints and concerns

- A number of complaints were reviewed during the inspection. However, none of these related to complaints about care provided to children. Staff told us how most complaints and cause for concern were dealt with face to face or through dialogue with a parent without the need for them to be raised formally.
- The complaints process was outlined in information leaflets, which were available on the ward areas and individual patient rooms
- Full details regarding complaint handling is contained with the surgery section of this report.

Are services for children and young people well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership and culture of service

- Although the number of attendances for children and young people was not high, the hospital did not have a

hospital wide group or committee to represent their interests. There was no separate department for children and young people and consequently no head of department.

- Compliance with safeguarding training was improving. However, staff could only recall one incident that had been categorised as a children and young people safeguarding incident. There had been nothing reported on the incident reporting system that related to children and young people. This demonstrated that there was little understanding of what may constitute an incident and the possibility that safeguarding concerns were being missed or not being reported.
- At the time of the inspection there was a specialist paediatric member of the Medical Advisory Committee.

Vision and strategy for this this core service

- The vision for the hospital was to be the independent sector hospital provider of choice in Surrey delivering first class care to their patients which resulted in excellent clinical outcomes. However, as there was no group across the hospital specifically relating to children and young people, we were unable to find any evidence of a specific vision and strategy for the provision of services for children and young people
- Although the hospital had stated that they had stopped seeing children as inpatients, we did observe that there was an advertisement on the notice board for a paediatric nurse to work on the ward. This was raised with senior staff during the inspection. A senior nurse told us that the advert should not have said that the nurse would be required to work on the ward and that the reason for recruiting a paediatric nurse was to provide support for the paediatric lead nurse.
- All senior staff we spoke with told us there were no plans to increase the provision of services for children although there was a commitment to improve the services that were currently offered. The physiotherapy service had looked to promote their service more widely although nothing had been formally agreed at the time of the inspection.

Governance, risk management and quality measurement

- Ashtead Hospital took the decision in August 2016 not to have children and young people as inpatients. They did however carry out blood tests and some minor procedures under local anaesthetic. They did not do any work with lasers or any ear, nose and throat procedures although they did carry out lingual frenotomy.
- The hospital did not carry out any audits on children and young people attending for outpatient appointments or physiotherapy appointments. This therefore prevented them from being able to measure the quality of the service they were providing. This also meant that any risks associated with children and young people attending were not being realised or acted on.

Public and staff engagement

- Staff told us that, at the time of the inspection the friends and family test was not appropriate for paediatric patients and that they would like a similar test designed solely for the use of children and young people and their parents or carers.

Innovation, improvement and sustainability

- The physiotherapy team was looking at ways that they could expand their service for children and young people. This had involved giving talks to general practitioners, consultants and making local schools aware of the service that they could provide. Although there had been no significant developments at the time of the inspection, this was an area where staff were looking to do more work.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- The hospital followed the Ramsay Healthcare UK Incident Policy, which was in date and due for review in 2019. The policy defined responsibilities in accordance with individuals' roles and required staff to report any incident or near miss, register the incident on the electronic incident recording system and participate in investigation and corrective actions as required.
- The electronic incident recording system was a risk management software system that the hospital used to report and analyse clinical and non-clinical incidents.
- The reporting period referred to throughout this section is July 2015 through June 2016 unless otherwise stated.
- There were 49 clinical incidents reported in the reporting period. The rate of clinical incidents is better than the rates for other independent hospitals for which we hold this type of data.
- There were seven non-clinical incidents in the reporting period. The rate of non-clinical incidents is better than the rates for other independent hospitals for which we hold this type of data.
- The outpatient departments did not report any patient deaths, 'never events' or serious incidents during the reporting period. 'Never Events' are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The occurrence of never events could indicate unsafe practice.
- The hospital reported no incidents of pressure ulcers, urinary tract infections in patients with a catheter (CUTI), blood clots or venous thromboembolism (VTE).
- The imaging department reported one Ionising Radiation (Medical Exposure) Regulations (IRMER) incident to CQC in the last 12 months. The incident was a technical fault with a machine. The incident was investigated and it was determined that that the field of view was too small but the machine did not and will not flag this up. This was an issue with the machine, which staff now know that they must manually address.
- Staff had a clear understanding of what was a reportable incident and were able to tell us the types of incidents and concerns that they should put on the electronic incident recording system. One staff member showed us the electronic incident recording system on their computer, demonstrated how they would make a report and told us that the system was easy to use.
- Another staff member said they had never reported an incident on the electronic incident recording system. They told us that when they had been involved in incidents, someone more senior had always been present and reported it. They told us they knew how to use the electronic incident recording system if they needed to.{cke_protected_1}
Staff reported that they were encouraged to report incidents. One stated 'if it bothers you' put it on the

electronic incident recording system. Another said they felt the electronic incident recording system created an environment that encouraged incident reporting. This reflected that the hospital encouraged a good incident reporting culture.

- Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which related to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened. We saw information about the duty of candour posted on the outpatient and imaging staff notice boards.
- Learning was taken and shared from incidents in the diagnostic imaging department. In one incident, the MRI scanner burnt a patient when a pad moved during a scan. The incident was reviewed and learning was shared at the staff meeting on 15 November 2016. We saw the minutes from the meeting had been placed in the communications folder. We saw staff signatures reflecting that staff had reviewed the meeting minutes. An information leaflet was attached to the notes, 'Safety Considerations – Implications with regard to the prevention of a radiography burn'.
- A staff member explained burns were a risk of the scan but that staff learned from the incident. Staff now advised patients to tell the radiographer if they felt heat or discomfort so it could be addressed. They explained that the patient involved in the incident had worried about ruining the scan if they raised their concerns. Staff now told patients that they would not ruin the scan or need to start over if they raised concerns.
- In another incident, staff scanned a patient's wrong site. Learning was taken and the department incorporated a 'Pause and Check' 6-point checklist for patient identification. We saw a sign reminding staff to 'Pause and Check' in the imaging room and a staff member described how they applied the checklist.
- Managers disseminated learning internally and the checklist, which we saw, was in use. The department sent a letter to the Ramsay Corporate Office so that other Ramsay imaging managers could share the learning.
- Staff explained to us that the hospital's Radiation Protection Supervisors (RSA) were on site and available as necessary. RSAs were specially trained Ramsay Diagnostic Imaging staff members. Their role was to ensure compliance with the Ionising Radiation Regulations 1999(IRR '99) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000. The RSAs were the first point of reference in the investigation of all radiation related incidents.
- In the event that Radiation Protection Supervisors needed further, expert support and advice, they referred to the Radiation Protection Advisor (RPA). The RPA was contracted from another hospital and was available to provide telephone advice as necessary. The RPA visited the hospital on a yearly basis to review the service.
- We saw that staff shared best practices across sites and departments. For example, managers told us about quarterly regional meetings where they met with other departmental managers to discuss issues, concerns and best practice. Staff members told us about other meetings and groups they were involved in, for instance head of department (HOD) huddles and meetings, infection control meetings, and health and safety meetings.
- However, we reviewed three incidents in the Outpatients department where there was no learning recorded. These included two separate sharps injuries, one involving a clinical staff member and one a cleaner. A sharps injury is an incident where a needle or other sharp instrument accidentally penetrates the skin. The third incident was a patient declining surgery due to a lack of information.
- We discussed the clinical staff member's needle stick with departmental staff. They said that no further action was necessary because the department was in the process of implementing the use of safer sharps already. This was a two stage process; first safer needles were employed, then safer instruments.
- Staff said two consultants were still using the old style needles; they explained that this was because of the

difficulty in using the safety needles in some specialised procedures. To manage the risk, doctors signed a disclaimer acknowledging the risk of using sharps which were not safety sharps and setting out the medical reasons for doing so.

- The staff member who received the needle stick injury told us that they received appropriate care and the patient involved in the incident was told what had happened.
- We reviewed the incident where a member of cleaning staff received a sharps injury while removing rubbish. We found there was no learning from the incident to prevent this from happening to other staff. This was not in compliance with The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Regulation 7, which required an employer to 'record, investigate and take measures to prevent the recurrence of an injury to an employee caused by a medical sharp where notified.'
- The provider had not identified the continued risk of needle stick injuries caused by the use of non-safety sharps or taken measures to lessen the continued risk of sharps injuries. So, there was a continued risk of sharps injuries to patients and staff.
- The log did not reflect learning about the lack of information complaint. The investigation reflected that the consultant had provided the patient with adequate information thus no learning was required.There was no investigation into why the patient reported that they had not received adequate information or further learning about the matter. So, there was a risk that patients may not be given adequate information to make a risk based decision.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from healthcare-associated infections. The outpatient departments were governed by the Ramsay Health Care UK Infection Prevention and Control policy, which was in date and due for review May 2019. The policy outlined the resources and infrastructure in place to reduce healthcare acquired infections. It referenced 35 Ramsay infection control and prevention policies. Some examples were, Aseptic Technique, Environmental Cleaning, Handling of Deceased Patients, Meticillin-Resistant Staphylococcus Aureus (MRSA), and Standard Infection Control Precautions.
- The policy provided a governance structure, outlined staff responsibilities, established auditing programs, and defined or required written, evidence-based or best practice policies, procedures and guidelines for the prevention and control of infection. The policies reflected relevant legislation and published professional guidance as reflected by their references.
- PLACE (patient led assessments of the care environment) assessments see local people go into hospital environments to assess elements of the environment that matter to patients. The hospitals Place score was 98% for cleanliness, which is the same as the England average.
- There were no infections of Meticillin-Resistant Staphylococcus aureus (MRSA) relating to the outpatient departments during the reporting period. MRSA is a type of bacterial infection; it is resistant to many antibiotics and has the capability of causing harm to patients.
- There were no infections of Meticillin-sensitive Staphylococcus aureus (MSSA) relating to the outpatient departments during the reporting period. MSSA is a type of bacteria in the same family as MRSA, but is more easily treated.
- There were no infections of Clostridium difficile (C.diff) relating to the outpatient departments during the reporting period. C. diff is a type of bacteria that can infect the bowel and cause diarrhoea.
- There were no infections of Escherichia coli (E.coli) relating to the outpatient departments during the reporting period. E. coli is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness and other illnesses.
- The outpatient departments used the Ramsay Health Care UK Hand Hygiene policy. The policy aimed to reduce the spread of infection through effective hand washing.

Good

Outpatients and diagnostic imaging

- The hospital had introduced a high visibility hand hygiene programme for patients and staff. We observed hand gels, available to patients and staff, on the walls throughout the department and at the entrance to the hospital.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We observed information displayed near sinks demonstrating the 'five moments for hand hygiene'.
- We saw staff and patients using the gel. We saw one staff member gel their hands on entering a consultant room to see a patient in accordance with the Ramsay Healthcare UK Hand Hygiene Policy.
- We observed one staff member washing their hands using hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care.
- Data received from the hospital showed that the Outpatients department hand hygiene compliance rate was 89% for July 2015, 92% for December 2015 and 94% for April 2016. This reflected improvement.
- All staff we saw in the departments were bare below the elbows to prevent the spread of infections in accordance with national guidance in compliance with NICE guidance.
- We observed three consultation rooms, one minor surgery room and the minor recovery room. All rooms observed were visibly clean.
- We saw cleaning schedules outlining each room's individual cleaning requirements (surfaces, blood pressure unit, exam couch, exam light, etc.). The schedules required the cleaners to initial each task when completed.This complied with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, "The arrangements for cleaning should include clear definition of specific roles and responsibilities for cleaning; clear, agreed and available cleaning routines…"
- We saw the schedules for 1 to 12 December 2016 for one outpatient consulting room. The record reflected that all cleaning was completed on the days the hospital was open. Closed dates were noted in the schedule.
- We reviewed cleaning checklists and found that on the day we were present five of the six consulting rooms cleaning checklists lists were complete. There was no evidence that the cleaners had cleaned one of the rooms. When we asked staff about this, they advised us that this was because a consultant had been in the room but that it would be cleaned.
- Staff advised us that cleaning occurred every night around 8pm and 9pm, and that the cleaning was generally to a high standard. Staff said if cleaning was not sufficient they could request someone return to re-clean but that this was rare.
- We observed five consultation rooms in the outpatient department. We saw that there was carpet in all of the consultation rooms we observed. This may not comply with the Department of Health HTM Health Building Note 00-09: Infection control in the built environment Hospital building note (3.82) which states that carpets should not be used as this area has a high probability of body fluid contamination.
- However, the flooring under the couches in the consulting rooms was covered with a hard, wipeable surface. Further, the hospital had risk reviewed the carpets. They concluded that the carpets, which reportedly met all required standards for use in a healthcare environment, were appropriate for treatment rooms. They concluded the rooms were appropriate for carpets due to the consulting room's low spillage risk. The hospital reported that there was a local cleaning schedule, plan for regular replacement and plan for replacement in the event of heavy soiling. This meant that the hospital was managing the risk associated with carpeted treatment rooms.
- Chairs and couches in the consultation rooms, theatre and recovery area were made of wipeable materials that could be easily cleaned and there were disinfection wipes readily available for cleaning furniture and equipment surfaces in the rooms.
- We observed that each room contained personal protective equipment including gloves in small, medium and large sizes. However, there were no aprons

in the consultation rooms. This did not provide evidence of compliance with National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England' (epic3), which says disposable plastic aprons must be worn when close contact with the patient, materials or equipment that pose a risk that clothing may become contaminated with pathogenic microorganisms, blood or body fluids.

- We did not observe close contact with a patient, materials or equipment so were not able to see whether aprons were used in these situations.
- We saw secure sharps bins were available in treatment and clinical areas where sharps may be used. We saw that these containers were labelled, none was filled above the fill line and all were in the appropriate partially closed position. This demonstrated compliance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, 5(1) d.
- There was a yearly external sharps audit. In the audit, outpatients scored 97.3% in May 2016, which was the same as their August 2015 score of 97.3%. In 2015 and 2016 audits, radiology scored 95.8% and physiotherapy scored 100%.
- We observed rubbish bins in all five rooms we observed. The bins contained little or no rubbish. All rooms had two separate colour coded bins with orange or transparent bags. However, the bins were unlabelled and there were no posters reflecting each bin bag colour's purpose. So, it was not clear which waste should go in which bin. This was not in accordance with the Department of Health (DH) Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations, section 5.24 which states that container labels should clearly identify the waste type(s) present within.
- We observed three treatment rooms in the Physiotherapy department.All had clean floors and surfaces. Waste bins were labelled although one room did not have a clinical waste bin. There were hand-washing directions beside the sink. There was hand gel available. The rooms were equipped with emergency pull cords.
- In the imaging department, we observed that the waiting room looked visibly clean. We saw ultrasound probes were cleaned between each use with a triple cleaning system. At the end of each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff had used. The records showed each time a probe was cleaned and reflected the three stages were completed. We saw records were complete.

Environment and equipment

- The Outpatients department had two waiting rooms, one for NHS patients and one for private patients. Both waiting rooms were clean, tidy and chairs all had wipe clean surfaces. Both waiting rooms had a television, leaflets, chaperoning notices and water. The private waiting room also offered coffee, tea and magazines. The NHS waiting room had a children's waiting area. Further information about these facilities is detailed in the Children and Young People section of this report.
- The physiotherapy and diagnostic imaging department each had small waiting rooms with wipe clean furniture and reading material.
- The hospital scored 96% in the PLACE assessment for condition, appearance and maintenance, which was better than the England average of 93%.
- We observed five consulting rooms in the Outpatients Department. The consulting rooms were tidy and equipped with a desk and chairs for discussions with patients, and a couch area for procedures. There was a trolley in the room which contained sterile disposable items such as syringes, needles and gauze swabs, all these items were in date. Disposable curtains were in place and had been changed within the last six months.
- We spoke to a staff member who saw patients in the outpatient department. The staff member said that they felt equipment was 'good' and they were happy with the levels of cleanliness.
- The staff member told us that the hospital was responsive to their request for up-to-date equipment or supplies. For example, to reduce infection risk, they requested preloaded lenses rather than lenses a nurse must load. In response, the hospital quickly supplied the preloaded lenses.
- One staff member told us that the department had needed a new piece of equipment because the existing one was ageing. They explained that one of the doctors

recommended a new machine and submitted a Capital Expenditure (CAPEX) bid for the equipment. The hospital had approved the bid and ordered the machine, which had just arrived. The company representative would train the nurses and then they would begin using the new machine. This meant the hospital ensured equipment was up to date and staff were safe and competent to use medical equipment on patients.

- We observed 10 pieces of electrical equipment. All 10 pieces of equipment had stickers indicating the equipment had been checked and was safe to use. We saw two pieces of equipment had labels that did not include the date the next service was due. However, we saw service contracts reflecting that a third party provided this service and it had occurred on a timely basis.
- We saw the facilities department's planned preventative maintenance (PPM) chart on the wall of the facilities office. The facilities staff used the chart to identify and monitor all PPM whether staff performed maintenance internally or employed an external contractor. This complied with Code of Practice on the prevention and control of infections and related guidance which required the provider, 'provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections'.
- Supplies were all well labelled, in date, in intact sterile packaging and easily accessible. We checked 33 items on two trolleys, all of which were in date and sealed. We checked over 100 supplies in cupboards across the department, all of which were also in date and sealed.
- We noted that staff labelled boxes of supplies with expiry dates within the next six months in red ink for easy identification. This was good practice and helped to ensure they used stock before the expiry date.
- Emergency equipment was located outside the treatment rooms in the outpatients department. The adult resuscitation trolley, with defibrillator, was in a secure position and sealed with an emergency tag. The checklist reflected that staff checked the top of the trolley daily and the defibrillator's PAT test was in date. We reviewed the trolley contents and all items listed on the checklist were present. We checked expiry dates on 28 items across the trolley and all were in date.
- We observed sanitising hand gel affixed to the walls throughout the outpatients department.
- In the Physiotherapy department, we observed the gym where therapists provided individual treatment and lead group physiotherapy classes. The room had a range of equipment and was visibly clean. There were disinfectant cloth wipes in the room for cleaning. Green 'I am clean' tags reflected the equipment had been cleaned.
- We saw the department had a bio-spill kit located prominently at eye level on a shelf approximately 4 feet above the floor.The kit could be used in the event of a blood or body fluid spillage and was in date.
- Fire exits were free from obstruction inside and outside the doors. In most cases, the fire exit routes were clearly marked. However, one intersection lacked a sign and it could have been unclear which direction to turn to reach the fire door. When we raised our concerns, facilities put up the additional sign within two hours.
- Each fire door should have an intact seal to create the fire barrier which restricts leakage in accordance with Health Technical Memorandum 05-02: Fire code Guidance in support of functional provisions (Fire safety in the design of healthcare premises) Annex C. Without the intact seal, the door may not provide protection in a fire. We identified a damaged seal on one fire door. When we raised concerns about the seal with the facilities manager, facilities repaired the door within two hours.
- The hospital's Diagnostic Imaging Department and equipment was governed by the Ramsay Healthcare UK Ionising Radiation Safety Policy which cited several regulations including (but not limited to) Ionising Radiation Regulations 1999(IRR '99) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.
- In the diagnostic imaging department, we saw specialist personal protective equipment, such as lead aprons in good condition. We saw records reflecting that the radiation protection supervisor had screened the equipment yearly. The equipment records showed good practice; they were up to date and included pictures of the equipment including condemned items. This complied with Ionising Radiation Regulations 1999 (IPP'99) sections 8 and 9.

- One staff member explained that staff were additionally encouraged to screen their own equipment for any fault which provided an added level of assurance.
- We noted that there were pregnancy signs in the imaging changing rooms, although there was none in the main waiting room. We saw that there was a working radiation warning light on the wall.
- The facility owned its own Magnetic Resonance Imaging (MRI), which was on the corporate replacement programme. Staff advised us that the machine would be replaced due to its age, although it was still operational. They explained that this would be a major process (a wall would have to be taken down to remove the large machine) and they had not yet gone through the process to select a new machine. Staff told us that the ultrasound machine was also on the replacement scheme due to its age, although it too was still operational.
- We saw quality assurance folders for the mammography and x-ray equipment. We saw the report from the radiation protection advisor's annual safety check on 15 March 2016 verifying equipment safety.
- However, we saw there were loose electrical cords on the floor of the ophthalmic suite, which could have created a trip hazard. We raised the matter and were told that staff would call facilities to address the cords.
- The toilet in the recovery room did not have a hand-washing basin in the room. A basin was situated directly outside of the toilet in the recovery room. This was not in accordance with Health Building Note (HBN) 00-09: Infection control in the built environment section 3.36. The regulation stated all toilet facilities should have a wash-hand basin.
- The tap on the sink in the gym poured directly into the drain. This did not comply with Health Building Note (HBN) 00-09: Infection control in the built environment section 3.49, which required taps not to flow directly into the drain. A tap flowing directly into the drain can cause splashing which could disperse contaminated water into the environment.
- We reviewed six fire doors. The fire map identified the locations of all interior fire doors. However, none of the doors was marked with the time that they were fire safe and two doors did not have signage identifying them as fire doors. This did not comply with Health Technical Memorandum 05-02: Fire code Guidance in support of functional provisions (Fire safety in the design of healthcare premises) Annex C which requires fire doors have an identification disc clearly indicating the fire-resisting standard of the door.

Medicines

- Staff told us that they do not administer controlled drugs (CDs) in the outpatients department. Our review of the drugs cupboard confirmed that there were no CDs present.
- We reviewed a drugs cupboard in the outpatients department. We found the cupboard was locked and drugs neatly stored and accessible. We checked 25 drugs all of which were in date and securely packaged.
- Staff reported that they date checked drugs weekly and performed a stock review every six months. Pharmacy also checked the drugs on the ward. They advised that there was no written record of the reviews so we were not able to verify the checks.
- Staff kept prescription pads locked securely in the department. The ward sister told us that, generally, nurses put prescription sheets on the consultant's desk before consultations. Nurses delivered the sheets individually or in an envelope of 10. In cases where the consultant rarely wrote prescriptions, nurses brought prescription sheets upon the physician's request. We did not find prescription pads in any of the rooms we observed, which reflected that the prescription pads and sheets were held in a secure manner.
- We reviewed two fridges where medications were stored. We observed locked fridges clearly displaying the temperatures.
- We reviewed the fridge temperature record book. The record book showed that staff checked temperatures every day that the facility was open and noted closed days. There were instructions in the back of the book which identified safe temperature ranges (2'C to 8'C) and provided guidance if the fridge temperatures were out of range.

- A staff member we spoke to told us about a power cut which caused the fridge temperatures to rise above the 2'C-8'C range. They told us that after the outage they had contacted the pharmacist who advised getting rid of most of the drugs, which they had done.
- However, on reviewing the temperatures recorded for December, we found that in one instance staff recorded a 9'C temperature. This was outside of the 2'C to 8'C range, but no further action was recorded. We asked a senior staff member about the record, they verified that the record showed that the temperature had been 9'C. They stated that they would expect to have seen further action taken and documented.
- The lead pharmacist investigated the out of range temperature after we raised it. They reported to us that they had spoken to the staff member who recorded the temperature. The staff member stated that the temperature had been at 9'C for 20 minutes but that they failed to record the 'in range' temperature reading 20 minutes later. The pharmacist verified that this was likely given the next temperature reading recorded.
- The pharmacist contacted the drugs' suppliers and verified that the increased temperature would not have harmed the drugs stored in the fridge. The pharmacist stated that, although there was no evidence that the temperature affected the emergency drug stored in the fridge, they had replaced it as a precaution to eliminate any possible risk that the drug would not work in an emergency. This meant that the issue was not picked up internally but it was addressed and resolved when it was raised during the inspection.
- The pharmacist reported they had discussed the outcome with the staff member who acknowledged that they should have followed the appropriate procedure after discovering the elevated temperature.
- For our detailed findings on medicines, please see the Safe section in the surgery section of the report.

Records

- The hospital used the Ramsay Healthcare UK Clinical Record Keeping Policy, which was in date and due for review March 2017. The policy stated that the minimum data set for outpatient records should include a GP referral letter, consultant outpatient notes taken during the appointment and additional requirements according to treatment plan. The consultation record should include the reason for the consultation, examination record, chaperone record, discussion of risks, benefits, and alternative treatments, diagnostics requested, agreed treatment plan, and reason for ongoing referral or referral back to GP.
- Patient paper records were stored in the medical records department and placed in the consulting rooms the morning before appointments for the consultant's review. Staff explained that the records were secure because they locked the consultant rooms. All rooms that we reviewed were locked except for the two rooms that were on the fire escape pathways. A nurse explained that staff did not leave records in these rooms but gave the records directly to the consultant. We reviewed one consultation room prior to a clinic and found that the room was locked and patient records were on the desk in the room. This complied with the Ramsay Clinical Record Keeping policy.
- Staff we spoke with stated that they had not had any problem getting the records in time for consultations. If the notes were not in the department, a nurse would call the medical records team and someone from the team would bring down the record or a nurse would retrieve it. The hospital reported that consultants saw less than 1% of outpatients without records during the reporting period from July 2015 to June 2016. This complied with the Ramsay Clinical Record Keeping policy.
- Standard practice was that hospital medical records were not removed from the site. However, historically consultants took private patients' outpatient medical records and held them offsite. This was identified as a risk and consultants now used carbon copy forms for their notes so that the hospital retained a copy of all notes.
- However, since introducing the carbon copy forms, the consultant took the original but left the carbon copy in the hospital records. This was not in accordance with the Ramsay Clinical Record Keeping policy, which stated in section 1.3, 'A Consultant may retain a copy of any part of the record (from outpatient consultation to final follow up consultation). The original of any clinical documentation must remain with the patient's health record.'

Good

Outpatients and diagnostic imaging

- We reviewed five sets of adult outpatient records. We found that, although the file folder holding the record identified the responsible consultant, the consultant who saw the patient was not identified in the notes and had not signed them on four occasions. The notes were not always legible and did not reflect the condition or treatment. This was not in line with the Ramsay Clinical Record Keeping Policy.
- A new computer system scheduled for installation in November was delayed; staff reported it had been delayed on several occasions. It was anticipated that it would be introduced in 2017. The new electronic patient records would prevent the need for records to be removed from Ashtead Hospital. On the new system it will be mandatory for consultants, nursing team and other clinical teams to upload their notes to the patients' record and for all of the multi-disciplinary team to access all patient records.

Safeguarding

- The Ramsay Healthcare UK Safeguarding Adults at Risk of Abuse or Neglect Policy outlined staff's responsibility to help prevent abuse and to act quickly and proportionately to protect people where abuse was suspected. The policy was in date and due for review in 2019.
- Staff reported receiving safeguarding training, which included on-line learning and a yearly in-person update at a mandatory training day. All staff we spoke to stated that they had received safeguarding training but were not necessarily able to identify their level of safeguarding training.
- There were no safeguarding concerns reported to CQC in the reporting period July 2015 to June 2016.
- We observed safeguarding information on the outpatient's bulletin board including safeguarding contact information and adult and children safeguarding flowcharts. Staff identified these as resources they could access when necessary. Staff we spoke to were able to identify the child and adult safeguarding leads by name.
- The overall safeguarding rates for Ashtead Hospital were 81% for Safeguarding Adults and 84% for Safeguarding Children. However, the department training tracker did not track safeguarding on-line learning. The tracker did reflect the mandatory training day attendance. It showed that in the outpatients departments, 67% of the 58 staff members required to attend the mandatory training day had complied. (Two staff members were new starters and two were on long-term sick leave.)
- For further safeguarding information please see the Children and Young people section of the report.
- The Mandatory Training Policy stated that mandatory training was essential and that all employees must annually complete the training. The outpatient departments were not in compliance with this policy because only 67% of departmental staff had fulfilled the mandatory training requirement (including safeguarding) as reflected by the training tracker.As a result, staff may not have been up to date with essential safeguarding training.
- Some staff were able to discuss situations where safeguarding would be appropriate and one staff member described their process when they had safeguarding concerns regarding an older patient.
- However, one staff member stated that they did not believe that they got 'that sort of thing' at the hospital. This did not reflect an understanding of the nature of safeguarding issues.
- Three members of staff were not able to state their training level for adult safeguarding. Female Genital Mutilation (FGM) training was not included in the training and staff did not reflect knowledge around FGM safeguarding. This did not comply with the Ramsay Adult Safeguarding Policy which requires that all staff are, at a minimum, trained to recognise, understand the impact of and take appropriate action regarding FGM.

Mandatory training

- The Ramsay Healthcare UK Mandatory Training policy was in date and due for review July 2018. It outlined mandatory training requirements presented in person or as e-learning including induction.
- The policy required current staff to fulfil their mandatory training needs through on- line learning. Staff explained to us that there was a yearly mandatory training day for all staff. The hospital's training tracker reflected this.
- The Mandatory Training policy and staff training tracker showed that staff members were required to complete

different training depending on their role. These could include varying levels of manual handing, life support, medical gases, venous thromboembolism (VTE) (a condition where blood clots form in a vein), AIM, consent, enhanced recovery, intravenous training, drug calculation, blood transfusion and venous collection.

- The training tracker showed that mandatory training rates did not comply with the company Mandatory Training policy requiring all staff to complete their mandatory training. The training tracker showed staff compliance rates for each individual module. For example, training compliance in the outpatient departments, by module, ranged from 17% (half day IV training) to 100%. This could demonstrate that staff did not have current knowledge in critical areas.

Nursing staffing

- The outpatient and diagnostics department employed 7.2 full time equivalent nurses and 3.4 full time equivalent health care assistants for a ratio of 2.1 health care assistants (HCAs) per nurse.
- The cross sectional radiology team employed four permanent radiographers, six bank (three regular) radiographers and one HCA. The general radiographer team employed three permanent radiographers, one bank radiographer and one HCA.
- A senior staff member explained that either the outpatient manager and sister or the sister and a senior nurse schedule staff in the Outpatients Department using the department rota. Generally, the rota included two trained nurses and one to three HCAs but these numbers flex depending on the number of clinics scheduled. Senior staff planned the rota four weeks in advance and modified it, as necessary, one week in advance. They did not use an acuity tool in outpatients.
- All staff we spoke to said that they were able to staff the department and the rota reflected the actual number of staff on a given day. The December rota and absence information confirmed this. The day we reviewed rotas two nurses and one HCA were on the rota and all were present which meant that the department was staffed adequately.
- Staff informed us that staff nurses or bank nurses cover shifts. Bank staff noted that the schedule is completed the week before shifts so they had adequate notice of changes to their schedule.
- The bank included three nurses, one who had years of experience at the hospital, one new nurse to the hospital and one who worked a regular weekly shift. The bank included two HCAs who began working at the hospital recently.
- A staff member confirmed that the nurses were experienced and that there was always a nurse available.
- We asked the provider to confirm the percentage of unfilled shifts from April 2016 to June 2016; however, we did not receive this information.
- The department used bank staff as a percentage of their total staff. From July 2015 to June 2016, 4% to 12% of nursing staff was bank staff. This ratio was similar to or lower than the average for other independent acute hospitals we hold this type of data for during the same reporting period.
- In the period from July 2015 through June 2016 1% to 13% of health care assistants were bank staff. This ratio was similar to or lower than the average for other independent acute hospitals we hold this type of data for during the same reporting period.
- There were no agency nurses or health care assistants working in outpatient departments from April 16 to June 16 (the most recent data available).
- Senior staff explained that the nurses have a variety of interests and skill sets and that they or the manager considered these and matched nurses to appropriate clinics, when possible, to provide an appropriate skills mix. This was confirmed by other staff we spoke with.
- Radiology staff told us that in cross sectional imaging all bank staff work with an intermediate life support trained permanent member of staff. We did not speak to bank staff to confirm this.
- The provider reported prior to inspection that in the last appraisal year, 43% of outpatients nursing staff and 21% of outpatients health care assistants received appraisals. However, the appraisal process had recently changed and appraisal rates had improved by the time

of the inspection. The hospital reported that appraisal rates had increased to 89% overall for the Outpatients Department and 91% overall for the Diagnostic Imaging Department.

- All staff we spoke to stated that they had received their appraisal this year and that they felt the appraisals were beneficial. This meant that when staff received their appraisals, they provided value to staff. One newer staff member explained that the appraisal helped with development. A more experienced staff member explained that they liked having an uninterrupted hour to discuss matters with their manager.
- Sickness rates for outpatient nurses were 0% in most months during the reporting period. This was lower than the average of other independent acute hospitals that we hold this type of data for in the reporting period (except for in February 2016 and April 2016 when there was a slight increase).
- Sickness rates for outpatient health care assistants were 0% in most months during the reporting period. This was lower than the average of other independent acute hospitals that we hold this type of data for in the same reporting period (except for in December 2015 when there was a slight increase).
- The provider had no vacancies for outpatient nurses or health care assistants at the time of the inspection

Medical staffing

- The hospital granted practicing privileges in accordance with the Ramsay Facility Rules dated 1 January 2013, there was no requirement to review these rules by a given date. Practicing privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these doctors also worked at NHS trusts in the area.
- The Ramsay Medical Director grants final approval in accordance with the Ramsay Corporate Credentialing Committee. A consultant applying for practicing privilege must submit a Ramsay DBS, current CV, Medical Indemnity Insurance, GMC registration, Appraisal, Speciality Certification, ILS training certificate, logbook and mandatory training.
- Generally, revalidation forms part of the annual appraisal conducted by the consultant's employing NHS Trust. If the consultant only performs private, independent work, an appraiser appointed by Ramsay Healthcare or an approved Responsible Officer (RO) supports the revalidation and appraisal process. A staff member we spoke with told us that they had a comprehensive induction with the managers, that the practicing privilege review had been strict, and that their primary NHS employer had performed their appraisal and provided it to the hospital.
- However, of six consultant records reviewed, three were missing Information Commissioner's Office (ICO) registration numbers, two were missing safeguarding information, and two were missing paediatric life support training details. This meant that the records did not fully reflect that checks had been completed and consultants were safe to practice.
- Staff reported that consultants control their own schedules planning clinics according to their own needs and patient demand.

Emergency awareness and training

- The hospital tested its fire alarm on a weekly basis.
- Staff explained to us that they had fire drills and knew what to do in an emergency. One staff member explained that, in the event of a fire during a minor procedure, they would establish if the fire was near and verify whether the consultant had time to finish a procedure, or bandage a patient, before evacuating.
- We reviewed the fire safety book, which verified regular fire drills and reflected that in the last fire drill the rates of evacuation, procedures and communications were all rated as 'good'. 'Good' was the best outcome on a scale from poor to good.
- The head of facilities explained to us that the fire doors all close automatically in the event of a fire and provide a fireproof seal for 30 minutes.
- Staff described their experience in crash bell practice scenarios. One staff member told us about the scenarios. They were able to explain the appropriate response for when the bell rang. Further, they told us about their reaction when the crash bell rang in a real situation, demonstrating that they were prepared and knew how to react in an emergency.
- A staff member explained that patient care did not often need escalation from outpatients. They explained that

in the event of an emergency or deterioration that nurses called 999 and the patient was transferred to a local hospital with an emergency department. There was no agreement with any specific local hospital. They explained that it would not be appropriate admit an emergency patient directly to Ashtead Hospital, as the hospital did not have an emergency department.

- Staff members explained that they do not use any Early Warning Scores to evaluate patients. Early Warning Scores are used to aid in early detection of declining patients by categorising a patient's severity of illness and prompting staff members to request a medical review. Scoring is an evidence based method to identify declining patients so they can receive care rapidly. The lack of early warning scoring could result in nurses not recognising patient deterioration or not acting on it as early as possible.
- In the Diagnostic Imaging Department, we saw that, in an emergency, staff could easily remove the table from the MRI machine and wheel it out of the MRI room. This ensured staff and patient safety and enabled timely response.
- Staff were not all up to date with their mandatory life support training. The training tracker showed that in the outpatients departments 40 staff members were required to be trained in intermediate life support (ILS) and 22 in basic life support (BLS). It reflected that 78% of the required staff members were up to date with ILS training and 77% with BLS training. This did not comply with the Ramsay Healthcare Mandatory Training Policy requiring that all staff fulfil mandatory training requirements and could mean that some staff did not have up to date, essential skills.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We rated effective as inspected but not rated.

Evidence-based care and treatment

- Current evidence based guidance, standards and legislation governed the Ramsay Corporate policies as reflected by the bibliography or references attached to each clinical policy. These cited National Institute for Health and Care Excellence (NICE) and the Royal Colleges guideline and other National guidelines and regulations.
- The Ramsay Corporate Journey Policy explained that patients should be treated using evidence based care. Patient pathways are a tool used to provide this care. One staff member explained that the pathways were updated this year and were now much better because the provided clear guidelines.
- Staff in the outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care citing National Institute for Health and Care Excellence (NICE) and other clinical guidance.
- One staff member said that they had no concerns about care because the patient pathways provided 'prescriptive' guidance to implement change. They understood the change and knew that it had an evidential basis.
- We saw confirmation of evidence based care throughout the outpatient areas. Evidence based policies guided the diagnostic imaging department. The Ramsay Ionising Radiation Safety policy cited Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2000) and the Health and Safety Executive, among other resources as the basis for the corporate policy. We saw these corporate policies, kept in conjunction with local rules, in a folder in the radiology room.
- The Diagnostic Imaging Department used the National Safety Standards for Invasive Procedures (NatSSIPs) Procedure checklist for ultrasound-guided injections, aspirations and biopsies. This had replaced the use of the World Health Organisation (WHO) checklist in the Diagnostic Imaging department.
- The Diagnostic Imaging department used the 'Pause and Check' 6-point checklist for patient identification. This was in line with the Clinical Imaging Board Patient Identification: guidance and advice and 'good practices' shared in CQC's IR(ME)R Annual report 2013.
- We saw NICE guidelines applied in the Physiotherapy department. For instance, we saw evidence based

guidance posted on the shockwave therapy machine. This guidance cited the clinical evidence for use of shockwave therapy and outlined applicable NICE guidelines.

- We witnessed a staff member discussing MRSA testing with a patient. We witnessed the staff member explain why MSRA testing was necessary before the patient's procedure. This was in line with the Ramsay Healthcare MRSA Screening Policy, which cites Department of Health Guidance as well as other resources.
- The hospital used technology and equipment to enhance the delivery of effective care and treatment. Staff we spoke with discussed the use of technology to enhance patient care and Capital Expenditure CAPEX to obtain up to date technology and equipment.
- A staff member explained that radiologists could choose to review scans from home using a secure system. As a result, they could report on scans more quickly.

Pain relief

- The Outpatients Department did not have a common tool used to measure pain in patients. Staff confirmed that the department did not use a specific pain management tool. A staff member told us, there was a plan for pain management competencies but this had not yet been introduced.
- One staff member told us that if a patient appeared to be in pain, they would ask about it. Sometimes they would use a scale of 1-4 to measure the level of a patient's pain. They said there was not much pain associated with the outpatient procedures they were performing.
- Staff explained that they have had internal Ramsay training about National Safety Standards for Invasive Procedures (NatSSIPs) to support staff using the new outpatient care pathways. The new Outpatient procedure care pathway included a line stating, "Patient states they have an acceptable pain score of 0-3 and has suitable analgesics at home if required". Therefore, it appeared that there was some formalised structure for pain relief. However, this had not been embedded in the Outpatient department.

Nutrition and hydration

- Two staff members explained to us that they routinely offered tea, coffee, and biscuits after procedures. They said that due to the nature of the procedures, more substantial food was not necessary.
- The staff members said they would otherwise only offer other food if there was a delay or if a patient needed it (for instance a diabetic patient). One staff member described a situation where a patient had fainted and they brought the patient tea and biscuits. The staff member monitored the patient until they believed the patient was safe to leave.
- Food was available in a hospital cafeteria. The hospital's PLACE score for organisational food was 94%, which was better than the England average of 91%.

Patient outcomes

- The hospital reported that it did not currently undertake clinical audits in the Outpatient department, although this was under review (the hospital did perform audits in the Physiotherapy and Diagnostic Imaging departments and the Outpatient department was included in infection control, external sharps and hand hygiene audits). The hospital's Clinical Audit Program 2015/2016 matrix confirmed that the Outpatients department was not included in the clinical audit program. A senior outpatient staff member advised that outcomes were not audited and they were not sure how the department measured outcomes.
- The Clinical Audit Program 2015/16 matrix reflected that audits of the Physiotherapy and Diagnostic Imaging departments were part of the hospital auditing program.
- We saw evidence of additional internal audits in the Diagnostic Imaging department. We saw the Diagnostic Imaging department had performed three internal audits: injection audit, dose audit and did not attend (DNA) audit. We saw actions arising from some of these audits. For example, staff used evidence of the local dose audit to establish the local standard based on actual exposure; we observed this information on the wall in the diagnostic imaging control area.
- The injection audit measured the number of attempts taken to give Computerised Tomography (CT) injections and the number of extravasation (process where any fluid or drug leaks into the surrounding tissue). A staff

member we spoke to explained that the numbers had remained comparable across the past two years but that they had not compared them to an outside source or target.

- The DNA audit measured the number of patients who did not attend or who abandoned the test before it was complete. Whilst there were no abandoned tests, 4% of patients did not attend for their radiological tests. The staff member explained that no action had been taken with regard to this audit but that they planned to use the information to increase attendance. They did not yet have a specific proposal for applying this information. This meant that they were collecting information, which they believed was important, and had not taken action based on the information, although they planned to do so.
- A staff member explained that the Physiotherapy department measured outcomes in various ways. For instance, they set SMART goals. The SMART (specific, measurable, attainable, realistic, timely) goals were evidence-based goals set by the physiotherapist with the agreement of the patient. The physiotherapists measured the number of units of treatment before discharge and whether the patient met goals within expected timeframes. The staff member explained that physiotherapists and consultants did not always agree on when the patient should be discharged. When necessary they said they could speak to consultants if discharge was planned but patients had not yet met their goals.

Competent staff

- Outpatient departments' staff generally felt that they or their managers had identified appropriate learning needs and they were encouraged and given the opportunity to develop their skills. This was a common thread throughout our discussions with staff.
- One staff member explained that, with 200 consultants, staff had to be prepared and trained to support different consultants with very different needs for example bariatrics, hip replacements and endoscopy. Staff could identify their own interests and learning needs. If staff requested training and could identify a benefit to the business, the staff member told us the hospital would usually support the training. They said that nurses and HCAs in the Outpatients department had received a wide array of training in addition to their mandatory training. For example training to assist with capsule endoscopy (the patient swallows a small camera in a capsule allowing the doctor to examine the gastrointestinal tract), photodynamic therapy (uses light-sensitive medication and a light source to destroy abnormal cells), and ear syringing.
- The staff member noted that they offered many specialised services requiring additional learning which was supported by the hospital. Physiotherapists pursued training in areas that interested them. Some of these included; acupuncture, shock wave therapy, paediatric physiotherapy, lymphedema management, hydrotherapy, and specialised areas such as golf and ballet physiotherapy.
- An entry level staff member we spoke with said that their development was always encouraged and that the hospital had offered them training to receive a professional degree. The staff member did not wish to accept this training, but had taken courses supported by the hospital, and had competencies signed off by senior staff. They noted that they felt they would be able to stay and progress at the hospital.
- Likewise, a senior staff member said that they were currently applying for funding to train HCAs in their department to become assistant practitioners. Another staff member had just been for a 'breast update' at a specialist centre.
- In the Diagnostic Imaging department, we saw certificates reflecting that all five permanent staff members had certificates to cannulate patients (insert a small tube into the vein). This meant the resident medical officer (RMO) or other medical staff would only have to attend for injections if there was only bank staff present or if Buscopan, which the radiologists do not inject, was necessary.
- Staff told us that they had yearly appraisals and one to one meetings, which they found useful. In the Ramsay Staff Engagement Survey 2016, 79% of hospital staff stated that they felt their performance development goals and objectives were achievable in comparison to 69% of Ramsay staff over all.
- In the Ramsay Staff Engagement Survey 2016, staff rated Ashtead Hospital 72% for career development. This was better than the 69% rating of Ramsay staff over all.

- Staff explained that nurses had received 'really useful' support in preparing for revalidation.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. Staff we spoke with discussed the value of multi-disciplinary team working.
- We saw evidence of multi-disciplinary learning and care. For example, one staff member explained the pre-assessment nurses, pharmacy and outpatient staff all share protocols and best practice in regular meetings.
- A staff member explained that they worked closely with outpatient nurses turning to them for their knowledge when necessary and for logistical assistance such as taking bloods when their department was short-staffed. This teamwork helped to keep patient appointments on time.
- Staff discussed how they worked closely with the anaesthetist and surgeon to make assessment decisions. We saw this when staff advised a patient that they would have to discuss pre-existing conditions with the anaesthetist and surgeon before treatment decisions could be made. This provided assurance that necessary parties were involved in making assessment decisions.
- A staff member explained that physiotherapy staff often liaised with nurses and the pharmacy department about patient care. Other departments were also involved in training for the Physiotherapy department. For instance, recently someone from pharmacy provided training about analgesics and someone from the infection control group spoke about infection control.
- Staff told us that nurses worked with physiotherapists to assist with wound care and dressing as necessary.
- We saw how the pharmacy department provided support to the outpatients department when a fridge temperature was elevated. The pharmacy department collected information about the incident, contacted pharmaceutical supplies for information, advised about what drugs needed replacement, and supplied the replacement drugs. When the pharmacy was involved, it provided assurance that staff managed pharmaceuticals using appropriate expertise.
- A staff member explained to us that multi-disciplinary collaboration stretched throughout the Ramsay organisation. They explained that outpatient departments' managers liaised to discuss ideas and best practices. For instance, they discussed sharps management when Ashtead changed its sharps policy.
- The staff member explained that managers sometimes visited other hospitals in the organization; they visited another hospital Outpatients department to see how that department ran. As a result, Ashtead made changes to prescription management. Likewise, the outpatient manager from another hospital recently came to Ashtead to learn from some of their methods.
- We saw that staff members of all levels and departments met to discuss concerns and share best practice at a wide array of meetings for instance, health and safety meetings, customer care meetings and infection control meetings.

Access to information

- Less than 1% of patients were seen without medical records in the outpatients departments in the three months prior to the inspection as reported by the hospital. If the service did not have the medical records in place before the patient attended an outpatient appointment, they would request the relevant information from the GP. This meant that consultants had the necessary information when they saw patients.
- The hospital reported that when patients were attending a follow up consultation in the outpatient setting, medical records pulled the notes the day before. However, if the medical records were not available on the day, copies of clinic letters were provided by either the medical secretaries or the NHS office. Any accessible images were requested from radiology ready for clinic.
- Staff members we asked were not able to recall a situation where they could not retrieve notes prior to an appointment.
- We saw the pre-assessment file for one patient. A staff member had collated and reviewed the forms for the

appointment. We observed the appointment where the staff member and the patient went over the forms and the staff member asked the patient to provide further information where the form was incomplete.

- Radiology staff told us that for every patient they had a safety screening form, patient assessment and consent form. They always had this documentation, which followed the patient throughout the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ramsay Healthcare had a consent to treatment for competent adults and children and young people policy, which was current and due for review in 2019. The policy outlined the rationale, responsibilities and processes for consent, and listed the four applicable consent forms and four information leaflets for patients about consent.
- Consent training was variable. The training tracker reflected that 100% of outpatient and physiotherapy staff completed mandatory consent training while 71% of imaging staff completed it. As it was mandatory training, all staff should have had this training under the Ramsay Mandatory Training Policy. Where staff had not completed the training, they may not have had up to date, necessary knowledge of consent and the process for obtaining consent.
- Ramsay Healthcare had a Deprivation of Liberties Safeguards policy, which was current and due for review in 2019. The policy defined deprivations of liberties and associated terms. It outlined the procedure for making a deprivation of liberties decision, requesting authorisation, review of authorisation, and the role of the Relevant Personal Representative (RPR). The appendixes included a mental capacity and best interest assessment form, a risk assessment form and a list of other relevant forms.
- The policy did not require specific training but it made the registered manager responsible for ensuring training was in place. The training tracker did not reflect any information about MCA and DOLs training or provide any compliance rates.
- One staff member we spoke to stated that they were aware of MCA and the different consent forms for people without capacity. They stated that they would refer to the posted flow charts or escalate matters if they had concerns about an MCA issue.
- We saw safeguarding and MCA flowcharts posted on staff noticeboards in the outpatient and imaging departments. We also saw posters about safeguarding, MCA and DOLs on both notice boards. Additionally the imaging notice board had a poster about 'patient choice' and managing patients who refuse x-rays.
- We saw an example of staff managing a patient where there was a question of the patient's capability to consent. The staff member followed the policy by involving senior staff to evaluate the patient's current ability to give consent. The department later used this incident as an example in the hospital's consent training.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- We saw staff providing compassionate care and patients reported that they felt staff were caring and friendly. We saw a staff member check on a patient who appeared to be confused. We saw them address the patient in a caring manner and make sure that the patient was happy, settled and understood what was happening before leaving them.
- We observed an appointment with a staff member, a patient and their supporter. We observed the staff member listening to each of the patient's concerns with regard to their health and the procedure, answering the questions and verifying with the patient that they understood.
- We saw that a staff member understood and acknowledged the patient's personal and social needs.

For instance, when the patient raised their concerns about personal responsibilities, the staff member listened and demonstrated that they respected these concerns by providing possible solutions.

- We saw that the staff member took the time to interact with the patient. When the patient asked about the procedure, the staff member answered each question completely, providing technical answers clearly and with a caring and reassuring attitude. The staff member managed expectations and told the patient when they would have to refer to the anaesthetist or surgeon.
- When the patient seemed unsure the staff member reassured them that they were asking good questions that demonstrated they were thinking about the procedure.
- One staff member explained that when communicating with a deaf patient they spoke face to face, pointed to written information and had the patient verify understanding, particularly with regard to consent. All of the interactions we saw were respectful and considerate of the patient's needs. The staff member always spoke directly to the patient although their supporter was present.
- Radiology staff explained how one staff member coordinated their patients' care. They made sure that tests were reported appropriately, invited patients to contact them before and after tests and came in at times that were convenient for their patients. This provided continuity in the care and reassurance to patients.
- Staff maintained privacy and confidentiality in the outpatients department. We witnessed consultants and nurses introduce themselves in the waiting room but no clinical discussions occurred in public spaces in the outpatient area. There was no confidential patient information (notes, patient names and personal information) on display in the outpatient public spaces.
- One staff member explained how they held covers over patient to maintain their privacy and dignity during procedures when the patient cannot be fully clothed.
- However, we did note that at the main front desk in the hospital, computers had privacy screens but, there was no private space for patients to discuss sensitive matters.
- The overall hospital PLACE score for Privacy, Dignity and Wellbeing was 74%, lower than the England average of 83%.

Understanding and involvement of patients and those close to them

- The staff took time to communicate with patients so patients understood and were involved in their own care. We witnessed a staff member explaining a procedure, and the impact of pre-existing conditions to a patient. The staff member used clear, direct language so that the patient could understand the risks, procedure and process.
- We saw a staff member recognise a patient's need for additional support during an appointment and provide the necessary clarity and reassurance to them. The staff member provided information empowering the patient to make decisions about their own care. For instance, they discussed risks of having, and not having, the procedure and what would happen if something went wrong.
- We observed the staff member provide pamphlets about PHE, MRSA and the National Joint Registry and point out contact information for getting further information. We also saw the staff member provide contact information for the hospital and preadmissions department and provide information about the hospital's hours over the holidays.
- We observed the staff member discussing community resources with the patient, including both their own community of friends and the community services available.
- Patients we spoke to explained that they received adequate information to make discussions about their care.One patient explained that they had received all the information they needed to decide whether to have elective surgery including explanations of the benefits and risks of the surgery.Another patient explained how their consultant had escorted them to see a nurse so that they could all discuss necessary tests.
- The Friends and Family Test (FFT) is a patient satisfaction survey for NHS patients using the hospital. The hospital's FFT scores from January to June 2016 were 98% to 100%. These scores were similar to the

Good

Outpatients and diagnostic imaging

England average of NHS patients at independent hospitals across the period from January 2016 to June 2016. Response rates were above the England average of NHS patients apart from in April 2016.

Emotional support

- Staff recognised the impact of care on the patient's emotional and social wellbeing. Staff members explained the importance of getting people back to the activities they cared about. One staff member told us how physiotherapists specialised in golf, ballet and other specialties to help people recover. We observed another staff member discussing with a patient how treatment would allow the patient to stay involved in community sporting activities that they enjoyed.
- We saw a staff member providing emotional support to a patient by supporting them in their decisions and offering reassurance about the decisions they were making.
- Staff members discussed how they provided emotional support to patients. One described chatting with patients to provide reassurance when they were nervous. Another staff member reported that they provided extra support to patients who were scared or nervous about scans. Before a scan, they would speak with patients on the phone or take patients for a tour of the department and machine. The staff member explained how things worked to patients to put them at ease. On the day of the scan they would give the patient extra time as necessary and put them into the MRI feet first, where possible, to reduce stress. The staff member would give the patient updates throughout the procedure as the staff member noted that, 'communication makes a world of difference'.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Ashtead Hospital treated NHS patients, self-pay and insured patients. They were responsive to these patients' requirements as reflected by the vision and strategy plans 2016. The hospital provided services aimed to meet these demands at times that were convenient to patients.
- The business had identified areas that they wished to grow in response to patient demand. These included sports injury, cosmetic surgery, bariatric, paediatric, spinal, urology, gynaecology and medical services.
- Two staff members explained that they also provided input about local demand. For instance, a staff member had noted that local doctors had stopped providing ear syringing through the NHS so there was a local need for this service. Three nurses trained in ear syringing and the outpatients department began offering this service.
- Staff told us that there was a daily private GP clinic for local patients. The hospital's website lists this clinic offering evening and weekend appointments.
- Outpatient appointments were generally available Monday to Friday from 8am to 9pm and there were Saturday clinics scheduled from 10am until 4pm based on patient demand and consultant request. The Diagnostic Imaging department was open Monday to Friday 9am to 5pm. The Physiotherapy department offered appointments 8am to 8pm Monday to Thursday, 8am to 5.30pm Fridays and 8am to 2pm on Saturdays.
- Staff we spoke to in all departments said that they could be flexible to accommodate patient schedules. For instance, one staff member told us they had seen a patient at 7:30am that morning to accommodate the patient. Another explained that they come in on Saturdays and weekday evenings to accommodate patient schedules.
- Staff were not able to tell us how to access pamphlets and fliers in other languages; however, staff we asked had never needed to do so.

Access and flow

- Patients had timely access to initial assessment and treatment and appointments generally ran to time.
- For patients on incomplete pathways, 100% of patients waited 18 weeks or less from time of referral during in the reporting period July 2015 through June 2016. During the same period, for 11 of 12 months, 100% of patients started non-admitted treatment within 18

weeks of referral. One month 99% started treatment within 18 weeks of referral. This exceeds the internal 90% target. This meant that patients were beginning their treatment within NHS and Ramsay targets.

- The hospital had no patient waiting six weeks or longer from referral for CT, non-obstetric ultrasound, dexa scan, colonoscopy, flexible sigmoidoscopy, cystoscopy and gastroscopy diagnostic tests in June 2016. The hospital had one patient (1.6%) waiting six weeks or longer from referral for magnetic resonance imaging diagnostic testing in June 2016.
- A radiology staff member reported that the wait time for private patients was two days for a scan. For NHS patients the wait time was about four weeks, comparing favourably with the six week target. They said that the hospital added Saturday clinics as necessary to keep waiting times low.
- Reporting times were good, the staff member reported that ultrasounds were reported immediately and all other scans were reported when the next radiologist was available, within 24 to 48 hours.
- Patients reported that appointments were available at convenient times and easy to schedule. One private patient told us their first appointment was booked within 24 hours, outpatient surgery within a week and physiotherapy within two weeks of original contact.
- Another private patient noted that the booking processes were 'immediate'.
- An NHS patient told us that they had waited two to three weeks from NHS referral to appointment. They said that they had had another appointment for the following week but when they asked if they could have an earlier appointment, they were able to reschedule to an earlier, more convenient, time for them.
- All staff we asked reported that in hospital waiting times were short. They worked together to minimise wait times, for instance a staff member explained that outpatient nurses stepped in to help in pre-admissions as necessary so that appointments did not run over.
- One staff member explained that they could see on their system if a patient had checked in and was waiting. If there were a significant wait, they would communicate this to the patient and keep the patient informed.
- We witnessed staff stepping forward to minimise patients' in hospital waiting time. For example, when there was a queue of patients waiting to check in at the front desk, we saw a staff member offer to check in radiology patients. The staff member was not reception staff but was walking by and offered to assist which reflected that the staff work together to attend to the patient flow.

Meeting people's individual needs

- The staff in the outpatient departments reflected that they met different individual needs using a variety of tools.
- Private patients in the Outpatients department were able to make an appointment with either male or female doctors according to their preference.
- Inpatients attending the Physiotherapy or Diagnostic Imaging department wore yellow socks and bracelet to alert staff to increased needs or risk.
- One staff member explained that they had recently had a patient wearing the yellow socks. This alerted them to the patient's increased risk and they reviewed the notes to see that the patient had an increased falls risk. As a result, two staff members helped the patient to transfer to and from their wheelchair.
- Another member of staff explained that when they worked with people living with dementia, they assessed the needs of the individual and provided appropriate care. In some cases, they would give the patient pictures, in other cases they would involve a carer or family member.
- Staff explained that while patients living with dementia used the facility, the patients could communicate and none was living with severe dementia. Two staff members we spoke with explained they had been on a dementia awareness course where they learned skills for communicating with patients living with dementia. Both would speak clearly, verify understanding and include carers when necessary as they had learned on the course.
- One staff member explained that when treating patients with learning difficulties they would make sure the patient was in a quiet area of the department and see them quickly. This minimised patient distress and made the appointment run more smoothly.

- Another staff member explained that while they could scan someone who was pregnant, there was a process to follow. The consultant was directly involved in the risk benefit analysis and discussed the test with the patient. The consultant was responsible for getting consent and a special consent form was used.
- A staff member explained there was an increased number of bariatric patients attending outpatients due to one consultant's increase in bariatric procedures. We noted that the blood testing chair was a bariatric chair and that there were chairs and couches suitable for bariatric patients. This meant that patients who came for bariatric services had places that they could comfortably wait and receive treatment.
- In physiotherapy, they noted that the hospital had purchased bariatric physiotherapy equipment but that it was now in storage as no one had used it. They said the equipment could be accessed if a patient needed it.
- A radiology staff member told us that they could provide MRI imaging for bariatric patients up to 133kg and CT scans up to 195Kg but larger patients were transferred to a facility with a larger MRI machine.
- We noted that there were no bariatric chairs in the diagnostic imaging waiting area but staff explained that the porters would bring bariatric chairs and a bariatric MRI safe wheelchair if necessary.
- Staff told us that the hospital had aids and devises to support patients with mobility issues.

Costs

- Private patients received cost information before the hospital provided any medical services. We spoke to a member of the administration staff who explained that medical admissions were a fixed cost and the hospital informed patients of costs, in writing, before admission. They said outpatients were advised of costs of appointments and tests by phone or in writing before services were performed. This meant patients were not surprised about costs or liable for more than they expected.
- The staff member explained that in some cases a nurse would advise of costs, for instance when the doctor ordered blood tests.
- One nurse we spoke to explained that they would discuss some costs with patients. If costs were prohibitive, they would revert to the consultant to decide if all tests were necessary and if they could perform tests in stages.
- Private patients each had a private patient account manager so they had one point of contact from referral to discharge.
- The costs of a variety of treatments were listed on the hospital's website. The website included the cost and a short explanation of what was included in the 'package price'.
- The administration staff member told us that for insured patients the hospital would call the insurer before care began to verify coverage. One patient we spoke to verified this.
- A patient told us that, although they were insured, they had received all of the cost information they needed about the treatment package. The patient said that they had been informed of the additional costs they would have to pay which included take home medications and a sling.
- We noted that the physical therapy department had posted some costs on the wall including the cost of thera-bands and of a physical therapy appointment post-consultation.

Learning from complaints and concerns

- The hospital used the Ramsay Healthcare UK Management of Patient Complaints Policy. The policy recognised the value of learning from complaints. However, learning was taken and shared in varying degrees in the outpatient departments.
- Patients were able to provide feedback to the outpatient service using a hardcopy feedback form, on line, or verbally. We were able to find the online feedback links on the hospital's homepage and Friends and Family Feedback forms in the departments.
- However, we were not able to find a paper complaints form in the outpatients department. When we asked a senior clinical member of staff where the forms were or how we would access them, they were not able to tell

us. This could have presented a barrier to complaining.It meant that a patient who wanted to complain would have to raise their complaint in person or search online for information about making a complaint.

- The staff member we spoke to in outpatients explained that they would assist any patient in making a complaint and attempt to help the patient to resolve the complaint.
- The Ramsay policy encouraged staff to resolve informal complaints immediately. It required that formal complaints, and those that could not be resolved immediately, be acknowledged within two working days and that a resolution letter be sent within 20 working days.
- There were 14 complaints made about the outpatient departments from February 2016 to November 2016. One complaint was made and resolved by phone in one day. The complaints tracker reflected that, of the remaining 13 complainants, 11 received an acknowledgement letter within two days, and 12 received a response within 20 working days.
- Four of the complaints addressed fees and three addressed delay. The hospital reduced the fees in two of the four fee based complaints.
- None of the complaints was reopened or escalated to the ombudsman or The Independent Sector Complaints Adjudication Service (ISCAS). One of the complaints was escalated to level two for the Regional Director's involvement. The patient met with the general manager, matron and imaging lead; the parties resolved the complaint at this stage.
- Staff in the Outpatient and Diagnostic Imaging department told us that learning was taken from complaints and incidents. Managers and staff shared learning at department meetings. Notes were taken from these meetings and put in communication folders in the outpatient and the radiology office space.
- We saw that notes from each meeting were in the communication folder. The notes we reviewed did not specifically reflect that discussions were a result of learning from complaints although they highlighted learning points. Staff signed to state that they had seen the notes and other communications on a monthly basis.
- A staff member explained that if learning were more time sensitive they would post the information in the office for all staff to see. We saw one notice posted in the radiography office.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The outpatient department's managers managed the Outpatients, Imaging and Physiotherapy departments separately. These managers each reported to the Matron who reported to the General Manager.
- There were clear lines of accountability in each department and staff had an understanding of their responsibilities and the management structure.
- Staff in all areas of outpatients reported that the department managers were in the department every day and involved in the day-to-day running of the department. Staff told us that the managers were approachable. Staff felt they could raise questions and concerns with managers.
- Both the general manager and matron were new to post this year. Staff told us that the matron and general manager were visible and approachable and they saw them in the departments on a regular basis. They told us that if they were not able to access their own manager that they would go directly to the matron for assistance.
- In the 2016 staff survey the senior management team was rated 58% for their modelling the Ramsay Way and 59% for taking staff opinion seriously. This compared to overall Ramsay staff scores of 59% and 54% respectively. However, it was not clear if this applied to the current management team. The survey was open from 18 January to 8 February 2016, before the matron accepted their role in March 2016 and the general manager in June 2016.
- Staff reported that they felt included in changes and that they were encouraged to be involved in working

groups and forums. In the April 2016 staff survey, 78% of staff stated that they felt they were valued by their team. This compared favourably against the 72% of Ramsay staff overall.

- Staff told us that their managers communicated messages to them in meetings. They particularly noted that managers provided information and messages after the monthly Heads of Department (HOD) meetings.
- All staff we spoke to told us that they liked their work and felt valued. Staff were able to tell us about times when their managers recognised their good work. The rate of outpatient nurse and health care assistant turnover was below the average of other independent acute hospitals that we hold this type of data for in the reporting period, July 2015 to June 2016. The report in July 2016 showed that there were no vacancies in the department.
- Likewise, sickness rates for outpatient nurses were 0% or lower than the average of other independent acute hospitals that we hold this type of data for in the reporting period, except for in February 2016 and April 2016 when there was a slight increase.
- Sickness rates for outpatient health care assistants were 0% or lower than the average of other independent acute hospitals that we hold this type of data for in the same reporting period, except for in December 2015 when there was a slight increase.
- Physiotherapy, nursing and radiology staff told us about how they worked together to provide safe and efficient care by supporting one another. For instance, they took on tasks to minimise patient waits and shared information and expertise.
- Nursing staff in outpatients told us that the ward sister and manager worked together to provide support and leadership. Staff told us their skills and experience complimented each other. Staff said that when the manager was absent they could turn to the sister for direction. If the sister was not able to provide direction, staff could raise concerns with the matron.
- Members of staff provided examples of times that they had raised concerns with the outpatient managers about consultants or the environment. The managers had raised the concerns with upper management and the issues had been resolved.

Vision and strategy for this this core service

- The provider had a clearly defined set of corporate values identified as 'the Ramsay Way'. The hospital's literature and on signage reflect the Ramsay values.
- The hospital vision was to be, 'a leading provider of healthcare services in Surrey by delivering high quality outcomes for patients and ensuring long term, sustainable profitability.' The hospital had 2016 clinical and business strategies to meet this goal.
- Throughout our interviews, staff repeated this aim to be the leading provider in Surrey or even in the country. This meant that the staff had absorbed this vision.
- Staff had an understanding of their role in achieving the vision. A staff member discussed how they incorporated the strategy into their work and how it fitted in the broader nursing values. They pointed out that these were not just the hospital's values but they were part of their own role.
- Staff members described how the best patient care and safety, staff care, engagement and evidence-based practice supported the business in its aim to be the best in the area.
- A manager we spoke with discussed the importance of taking care of staff to retain them. To do this they encouraged HCAs to progress to assistant practitioner roles, and assured everyone was doing interesting and varied work by rotating staff members between two Ramsay hospitals.
- Staff described how the customer-care working group identified ways to improve care to all customers, internal and external.
- As we spoke to staff throughout outpatients they described a wide variety of working groups that they were involved in to be a part of identifying and instituting change. A member of the senior management team explained that these groups supported change as well as engaging staff members at all levels, particularly newer staff.
- Evidence reflected that the outpatient departments had incorporated parts of the 2016 strategies, but they had not yet fully implemented them. For instance, one aim was to promote safeguarding by maintaining a training spreadsheet. A training spreadsheet had been

employed but, safeguarding training was not defined on the spreadsheet we reviewed and staff we spoke with were not all able to identify their level of safeguarding training.

Governance, risk management and quality measurement

- All policies used by Ashtead Hospital were Ramsay Healthcare Corporate Policies. This should have provided continuity of practice across the system. The corporate policies were evidence based, in date and reviewed regularly.
- There was a governance framework to support the delivery of the strategy and good quality care. This was made up of the Heads of Department and several risk and governance groups (including clinical governance, infection control, health and safety) that fed into the MAC. The MAC met four to five times a year and encompassed all specialties.
- We saw that risks were weighed and managed on a departmental level. Risks assessments were performed and documentation was held in the departments. Some matters were escalated to the Heads of Department (HODs) for further review and action.
- In each of the outpatient departments we saw that policies, plans and risk assessments were kept in paper form and available for staff to review. We saw evidence that staff turn to polices to provide help and direction, for instance when a staff member had concerns about consent.
- Staff reported that they were aware of their responsibilities and knew how to report risks and near misses on the electronic incident recording system.
- Staff in all of the outpatients departments demonstrated their holistic understanding of the integration of safety, quality and care equating to high performance.
- Management reviewed complaints and incidents but the MAC reviewed issues that were more serious. We saw that managers escalated staff concerns. Information discussed at the MAC and HOD meetings was cascaded to staff at team meetings and via the communication books.
- We did not see that the Outpatients department relied on audits to manage risk and measure quality. Information provided by the hospital stated that auditing in the outpatient department was under review. There was an outpatients' risk register which identified nine risks, all of which were rated as low.
- We saw evidence of audits taken in the radiology and Physiotherapy departments. We saw that the dose audit informed the local dosage rates. We saw that staff collected and collated information for other audits, but it was not necessarily used to inform decisions.Staff members told us that they planned to start using the information to direct change.

Public and staff engagement

- Staff members were encouraged to complete the staff survey. The April 2016 engagement survey reflects that 67% of staff were satisfied with their level of involvement in decisions affecting their work and 80% felt empowered to make decisions appropriate to their role. This compares favourably to the overall Ramsay results, which were 67% and 71 % respectively.
- Staff reported that they were encouraged to join engagement groups and felt that this added value to the hospital. One staff member gave examples of their involvement in customer care, another pointed to staff on the clinical governance, infection control and health and safety groups who fed back to the teams at team meetings.
- There were forums for staff to engage with management including meetings, working groups and via their direct line manager.
- There were various ways for patients to provide feedback. We observed Compliment cards posted on outpatient waiting room walls (although there were no complaints forms) and there was a feedback section on the hospital's website. Managers shared feedback with the team members affected. We saw two thank you cards posted on the outpatient nurses bulletin board.
- We saw staff noticeboards displaying information about a variety of subjects, for example an organisation chart, the reporting structure, incident reporting, safeguarding, flowcharts, policies and phone numbers for useful organisations.

Innovation, improvement and sustainability

Good

Outpatients and diagnostic imaging

- There was a culture of innovation through learning and training at the hospital. Staff at all levels throughout the outpatients departments reported that they were encouraged to increase their skills and knowledge by identifying and utilizing training opportunities.
- For instance, staff explained that the Physiotherapy department was continually improving through training and innovation. They have identified therapies, which patients value and therapists have trained in a wide array of specialties for example, therapy for golfers, acupuncture, workplace station reviews, hydrotherapy, and migraine therapy.
- The hospital had identified the needs and interests of their patients to help develop the service, for instance, they identified increasing bariatric offerings as a way to serve patients and increase uptake of services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure all staff have undertaken mandatory training.
- Ensure governance strategies and processes are embedded throughout the hospital.
- Ensure patient records in outpatients and the children and young people's services are complete and comply with Ramsay policy.

Action the provider SHOULD take to improve

- Ensure that staff throughout the hospital have the required level of safeguarding including updates as required and that safeguarding systems are fully embedded.
- Address any continued risk of sharps injuries to patients and staff in the outpatients service.
- Ensure information about making complaints is available to patients in outpatient departments' public areas.
- Ensure that necessary improvements are made when things go wrong and learning is taken from incidents occurring in the outpatient service.
- Ensure bin labels within the outpatient departments clearly identify the waste type(s) present within.
- Ensure all sinks in the outpatients service are compliant with the Health and Safety Executive regulations.
- Ensure a methodology for measuring and recording patient pain levels is used and embedded across the outpatient department.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Not all staff who were trained to the right level in mandatory training areas. Staff mandatory training compliance by module varied between 13% and 100%. Safeguarding training did not meet the hospital target of 90%. The hospital did not demonstrate that all employees received training necessary to enable them to carry out the duties they are employed to perform. This breached Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing part 2(a).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The governance arrangements did not adequately ensure governance strategies and processes were embedded throughout the hospital to manage risk and measure the quality of the services provided. This breached Regulation 17 HSCA (Regulated Activities) Regulations 2014 Good governance.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to

the service user and of decisions taken in relation to the care and treatment provided.

Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Patient records in outpatients and the children and young people's services were not all complete and did not all include the original documents.