Blakelands Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Blakelands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital provides surgery, and outpatients and diagnostic imaging. We inspected these services. The hospital has two theatres, one that is used for surgical procedures including orthopaedic, general and ophthalmology (eye) surgical procedures. The second theatre is used for endoscopy procedures. There are recovery stage one and recovery stage two areas. The recovery stage one area has four trolley spaces, and the stage two area has four chairs. Other facilities include general x-ray, ultrasound, five outpatient treatment rooms and a reception area.

The hospital provided services to adult patients (over 18 years old).

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 5 October 2016 along with an unannounced visit to the hospital on 14 October 2016.

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

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

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

We rated this hospital as good overall.

- There was a positive incident reporting culture, with good evidence of learning from incidents.
- Staff understood their roles and responsibilities to safeguard adults from abuse.
- Nurse staffing levels were appropriate for the service. Medical staff practicing privileges were monitored to ensure doctors were suitable and safe to work in the service.
- Medicines were checked, monitored and managed appropriately.
- Staff were kind, respectful and always introduced themselves.
- The June 2016 patient survey showed that 96% of patients would recommend the hospital to their friends and family.
- The management team were visible and approachable.
- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.

We found areas of good practice in surgery:

- There were incident reporting processes in place.
- There were robust infection prevention and equipment maintenance procedures in place.
- The hospital achieved 100% of NHS patients treated within 18 weeks of referral from July 2015 to June 2016.
- Pre-operative fasting information sent to patients was aligned to the recommendations of the Royal College of Anaesthetists.
- The average length of patient stay was reported to be less than four hours (September 2016).

Summary of findings

- Patients with cancelled operations were offered another appointment within 28 days of the cancelled procedure.

We found good practice in relation to outpatient and diagnostic services:

- There were incident reporting processes in place.
- The hospital had no patients waiting six weeks or longer from referral for non-obstetric ultrasound.
- Staff mandatory training rates were 100%.
- Patient notes were stored securely.

We found areas of practice that require improvement in surgery:

- The risk register was not always used as a tool to manage risk actively at a departmental level and we identified risks that were not included in the risk register.
- We found that not all surgical site infections that were reported had an associated root cause analysis report. Therefore, we could not be assured that the organisation was investigating and learning from all reported surgical site infections.
- We were not assured that the World Health Organisation five steps to safer surgery checklist was completed consistently in line with the three stages. This increased the potential risk of a patient safety incident occurring.
- There was not a service level agreement in place for patients requiring transfer if they became critically ill.

We found areas of practice that require improvement in outpatient and diagnostic services:

- Audits were not always followed up with appropriate actions to ensure the service improved.

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 one requirement notice that affected surgery and outpatient and diagnostic services. Details are at the end of the report.

Ted 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 surgery service as good overall. We rated the service as good for safe, effective, caring and responsive to people's needs. We rated it requires improvement for being well-led. • There were systems and processes in place to protect patients from avoidable harm including incident reporting, medicines management, infection prevention and control and staff mandatory training. • Staffing levels were appropriate and staff understood their responsibilities regarding safeguarding, consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. • Patient's care and treatment was planned and delivered in line with evidence-based guidelines. For example, the pre-operative fasting information sent to patients was aligned to the recommendations of the Royal College of Anaesthetists. • The team worked well together and patients told us they felt listened to by staff and able to ask questions about their care and treatment. • Access to treatment was good, with 100% of NHS patients treated within 18 weeks of referral from July 2015 to June 2016. Due to day case surgery, the average length of patient stay was reported to be less than four hours (September 2016). • The senior management team were visible and approachable. However, • We found that not all surgical site infections that were reported had an associated root cause analysis report. Therefore, we could not be assured that the organisation was investigating and learning from all reported surgical site infections.

Summary of findings

- The hospital had a service level agreement (SLA) in place with a local NHS trust. This was for patients needing to be transferred for overnight care and observation. However, this SLA did not cover transfer for critical care.
- There was an audit programme in place. However, areas of weakness were not always followed up with appropriate actions to ensure the service improved.
- The risk register was not always used as a tool to manage risk actively at a departmental level and we identified risks that were not included in the risk register.

Outpatients and diagnostic imaging

Good

We rated outpatient and diagnostic services as good overall.

- There were incident reporting processes in place.
- Staff understood their roles and responsibilities to safeguard adults from abuse.
- The hospital had no patients waiting six weeks or longer from referral for non-obstetric ultrasound.
- Staff mandatory training rates were 100%.
- Patient notes were stored securely.
- Nurse staffing levels were appropriate for the service. Medical staff practicing privileges were monitored to ensure doctors were suitable and safe to work in the service.
- Staff were kind, respectful and always introduced themselves.
- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.

However:

- Audits were not always followed up with appropriate actions to ensure the service improved.
- Staff were not all aware of the strategy and vision of the hospital.
- Staff were not aware of the acceptable temperature limits for the safe and appropriate storage of medicines.

Summary of findings

Contents

Good

BlakelandsHospital

Services we looked at
Surgery; and Outpatients and diagnostic imaging.

Summary of this inspection

Background to Blakelands Hospital

Blakelands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital/service opened in 2006. It is a private hospital in Milton Keynes, Buckinghamshire. The hospital primarily serves the communities of Buckinghamshire, Bedfordshire and parts of Northampton. Blakelands Hospital is under the NHS tariff system provides care for orthopaedic, ophthalmic, general surgery and gastroenterology specialties, with a radiology diagnostic suite for x-ray and ultrasound.

The hospital has had a registered manager in post since December 2010. The current manager registered with the CQC in November 2015.

Our inspection team

The team that inspected the service comprised a CQC inspection manager Charlotte Rudge, three other CQC inspectors, and two specialist advisors with expertise in theatre and radiology.

Information about Blakelands Hospital

The hospital is registered to provide the following regulated activities:

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

The hospital employs 29 doctors under practising privileges. There are no registered medical officers (RMOs) as this is a day surgery hospital with a consultant present when treatment is undertaken.

There were no special reviews or on-going investigations of the hospital by the CQC at any time during the 12 months before this inspection. The hospital had been inspected once previously in 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

During the inspection, we visited areas including, theatres, admission and recovery areas, outpatient and x-ray departments. We spoke with 15 staff including; registered nurses, health care assistants, medical staff, operating department practitioners, senior managers, the registered manager, the chair of the medical advisory committee (MAC).

We spoke with 13 patients and their relatives. We also received 105 'tell us about your care' comment cards which patients had completed prior to and during our inspection. During our inspection, we reviewed nine sets of patient records. We also observed the care staff provided to patients.

Activity (July 2015 to June 2016)

- There were 3,686 day case episodes of care recorded at the hospital; of these 98% were NHS funded and 2% were other funded.
- No patients stayed overnight at the hospital during the same reporting period.
- There were 8,541 outpatient total attendances; of these 97% were NHS funded and 3% were other funded.

29 surgeons and anaesthetists worked at the hospital under practising privileges. Blakelands Hospital employed 10 registered nurses, six care assistants and one radiographer.

The accountable officer for controlled drugs (CDs) was the matron.

Track record on safety (July 2015 to June 2016)

Summary of this inspection

- No never events
- 73 clinical incidents, all of which were graded as no harm. 70% (51 incidents) occurred in surgery and other services. The remaining clinical incidents 30% (22 incidents) occurred in outpatient and diagnostic services
- The hospital reported 0% of all incidents as severe or death
- No serious injuries
- No incidences of hospital acquired MRSA
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile
- No incidences of hospital acquired E-Coli
- Rate of complaints per 100 day case and inpatient attendances was lower than the rate of other independent acute hospitals (19 complaints)

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services outsourced by the hospital:

- Agency staff
- Electrical safety testing
- Cleaning services
- Clinical waste and non-clinical waste removal
- Interpreting services
- Pathology service
- Histopathology services
- Critical care transfer
- Infection control advice
- Pharmacy services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were robust infection prevention procedures in place.
- There were systems in place for staff to complete mandatory training in a range of subjects. Compliance ranged from 84% to 100%.
- Medicines were checked, monitored and managed appropriately.
- Patient notes were stored securely. There were care pathway documents that were used to record the patients' journey through their care and treatment.
- Staff understood their roles and responsibilities to safeguard adults from abuse. However, not all staff were up-to-date with safeguarding training.
- Nurse staffing levels were appropriate for the service. Medical staff practising privileges were monitored to ensure doctors were suitable and safe to work in the service.
- Staff completed emergency scenario training.
- The national early warning score (NEWS) was used to identify deteriorating patients.
- Equipment was appropriately maintained and fit for purpose.
- We were not assured that the World Health Organisation five steps to safer surgery checklist was completed consistently in line with the three stages. This increased the risk of a patient safety incident occurring.
- There were incident reporting processes in place. However, not all surgical site infections that were reported had an associated root cause analysis report. Therefore, we could not be assured that the organisation was investigating and learning from all reported surgical site infections.
- The hospital had a service level agreement (SLA) in place with a nearby NHS trust. This was for patients needing to be transferred for overnight care and observation. However, this SLA did not cover transfer for critical care.

Are services effective?

Good

We rated effective as good because:

- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- Patient pain levels were well managed and monitored.
- There was a 68% appraisal rate for staff for 2016.

Summary of this inspection

- Staff demonstrated a good knowledge and understanding of obtaining consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Pre-operative fasting information sent to patients was aligned to the recommendations of the Royal College of Anaesthetists.
- We observed that the team worked well together. It was a small facility and this assisted with maintaining good multidisciplinary working.
- Staff had access to the information they needed to deliver effective care and treatment.

Are services caring?

Good

We rated caring as good because:

- Staff were kind, respectful and always introduced themselves.
- The June 2016 patient survey showed that 96% of patients would recommend the hospital to their friends and family.
- Patients felt listened to by staff and able to ask questions about their care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- The hospital achieved 100% of NHS patients treated within 18 weeks of referral from July 2015 to June 2016.
- The hospital had no patients waiting six weeks or longer from referral for non-obstetric ultrasound.
- Staff adjusted their care and treatment to meet the individual needs of patients.
- There was a robust complaints procedure and staff had feedback about complaints received.
- The average length of patient stay was reported to be less than four hours (September 2016).
- All cancelled patients procedures were offered another appointment within 28 days of the cancelled procedure.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The risk register was not always used as a tool to manage risk actively at a departmental level and we identified risks that were not included in the risk register.
- We found that not all surgical site infections that were reported had an associated root cause analysis report. Therefore, we could not be assured that the organisation was investigating and learning from all reported surgical site infections.

Summary of this inspection

- Audits were not always followed up with appropriate actions to ensure the service improved.
- There was a clinical strategy for the hospital for 2016 to 2019. Understanding of the strategy was clear at a senior level. However, this was less clear at a departmental level.
- Staff we spoke with were able to summarise the hospital values and discussed the 'Ramsay way', which was a corporate set of values.
- The management team were visible and approachable.
- Staff felt that they worked within a good team and that they all worked well together.
- There was a patient focus group to improve services.

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	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both outpatients and diagnostic imaging.

Good

Surgery

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

Information about the service

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

Are surgery services safe?

Good

We rated safe as good.

Incidents

- A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. There had been no never events or serious incidents reported by this service from July 2015 to June 2016.
- The hospital used an electronic incident reporting system to record incidents. Staff told us that anyone could report an incident. Staff were able to discuss incidents that they had reported and gave examples of these. Staff told us that they were encouraged to report incidents. They felt that they received feedback following reporting incidents and their line manager or matron provided this. The minutes of meetings, including the medical advisory committee, included discussions about incidents that had happened.
- From July 2015 to June 2016, there were incidents reported by the surgery team. Six of these were classed as non-clinical incidents. All of the incidents were categorised as resulting in no harm.
- From August 2015 to April 2016, four incidents were reported that were near misses related to potential wrong site or incorrect surgery. In all of the cases, the errors were noted before surgery, so there was no resulting harm and the patients received the correct procedure. Some of the incidents related to incorrect booking information. This issue had been added to the hospitals risk register. This meant that staff were reporting near misses in order to prevent incidents reoccurring. This also meant that effective safety checks were in place before patients had surgery. Action plans associated with the incidents, included discussing the incidents with staff at meetings. We saw evidence that this had taken place.
- Duty of candour: As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff we spoke with were generally aware of the regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them.

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

- The hospital did not use the safety thermometer or clinical quality dashboard due to having only day case surgeries.

Cleanliness, infection control and hygiene

Good

Surgery

- Patients were asked to complete a medical questionnaire before they attended the hospital for a procedure. The questionnaire contained a section about infection risks, including any previous MRSA or Clostridium difficile infections. This meant that the service could make any necessary arrangements related to infection prevention and control prior to the patient's arrival.
- The environment and the majority of equipment in the surgical department was visibly clean and tidy. There were cleaning schedules that were consistently signed to advise that areas and equipment had been cleaned regularly. We also found that items had been labelled to indicate when they were last cleaned. However, we found that one of the trolleys in the recovery area was dusty. We informed staff at the time who rectified this. During our unannounced inspection, we checked five trolleys at random in clinical areas and found them to be visibly clean.
- From July 2015 to June 2016, five patients developed surgical site infections (SSIs) following orthopaedic procedures at Blakelands Hospital. The rate of SSIs per 100 operations performed, was above (and therefore worse than) the rate of other independent acute hospitals we hold this type of data for. We requested details of the investigations carried out following the infections. One root cause analysis report was provided, which found that the infection was unavoidable due to the risk of the type of procedure that was performed. Therefore, we could not be assured that the organisation was investigating and learning from all reported SSIs. However, the theatre team did undertake audits regarding best practice related to SSIs. The results were 91% in November 2015 and 100% compliance was achieved in February 2016.
- Hand washing facilities and alcohol based hand gels were readily available for patients, staff and visitors in all areas of the unit and were used consistently during the inspection. This met the requirements of the World Health Organisation (WHO) guidelines for hand washing, Health Building Note 00-09 Infection control in the built environment, and the Department of Health code of practice on the prevention and control of infections (the Code).
- We saw staff complied with the WHO Five Moments of Hand Hygiene and the provider's infection prevention and control policies. This included being 'arms bare below the elbow', hand washing before and after every episode of direct patient contact or care, and correct use of protective personal equipment, such as disposable gloves and aprons. We saw that staff wore eye protection masks when undertaking certain procedures, for example, during endoscopy and complied with theatre attire policies.
- We saw that systems and processes were in place for decontamination of reusable medical devices. This included separate areas for clean and dirty equipment and electronic tracking systems for used endoscopes. Endoscopes are lighted, flexible instruments used for the examination of the inside of the body during procedures called endoscopies. The decontamination of reusable medical devices was carried out in line with national guidance (Health Technical Memorandum 01-06).
- There was a difficult airway trolley in theatre that was checked and cleaned regularly and we saw records of this. However, there was a scope in the trolley for use in an emergency. This had been cleaned and placed in a protective bag in March 2016. We discussed this with senior staff during the inspection, who advised us there was no policy or procedure in place for this scope. At the unannounced inspection, we found that the scope had been replaced with a disposable version of the device. This meant that the device could be discarded after use and did not require cleaning and storing.
- Local audit results at the hospital showed 96% to 100% compliance with hand hygiene standards from July 2015 to April 2016.
- The hospital used disposable curtains between recovery bays for privacy and dignity. They were all dated to indicate when they needed changing. Staff told us that this was every three months unless contaminated in the meantime.
- The hospital's annual patient led assessments of the care environment (PLACE) in 2015 scored 100% for cleanliness.
- Staff at the hospital completed mandatory training in relation to infection prevention and control and compliance was 96% at September 2016.

Environment and equipment

Good

Surgery

- The hospital had two theatres, one that was used for surgical procedures including orthopaedic, general and ophthalmology (eye) surgical procedures. The second theatre was used for endoscopy procedures. The theatres did not have laminar flow, which is a ventilation system for infection prevention. This was not required for the types of procedure that were carried out at Blakelands Hospital. Also in the department were bays for patients to recover and be monitored closely following procedures. Then there was a seated recovery area, where patients could wait until ready for discharge.
- The hospital's annual PLACE in 2015 scored 100% for the condition appearance and maintenance of the environment.
- We found that there was appropriate resuscitation equipment available in case of an emergency. This was on a resuscitation trolley available in the recovery area. It had a tamper evident seal system in use. We saw records indicating that the trolley and its contents were checked regularly.
- There was a difficult airway trolley available in theatres, in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. However, there was no list of contents for the trolley and no checking procedure in place. This meant that we could not be assured there would be the required equipment available in an emergency. We raised this during the inspection and senior staff told us that this would be addressed. At the unannounced inspection, we found that a contents list and a weekly checking process had been put in place.
- We saw that the anaesthetic machine in theatres had been checked appropriately and records of checks and weekly breathing circuit changes were documented.
- Equipment we checked during the inspection had been serviced appropriately and had been safety tested.
- There was also a hoist available in the hospital to assist with patient moving and handling if required.
- We saw and staff advised us that there was a spillage kit available in the dirty utility area in the department.
- Weekly water testing was carried out, such as testing and legionella. These were discussed at the infection control meetings and no issues had been raised.
- The infection prevention and control meeting for July 2016 had noted that the had met requirements

Medicines

- The hospital did not have an onsite pharmacy. There was a pharmacy service provided which was outsourced. The pharmacy provider carried out monthly audits including the storage and administration of controlled drugs (CDs). The pharmacist told us there had been the occasional documentation error that had been found and actions had been taken.
- We saw during the inspection that the controlled drugs (CDs) were checked twice daily and records completed to indicate this.
- There had been an inspection by the Home Office regarding a license for CDs at the hospital and this had been approved in September 2016.
- The hospital carried out medicines management audits according to the local audit programme, which was set corporately by Ramsay Health Care UK Operations Limited. We noted that an audit carried out in April 2016 scored an overall compliance rate of 77%. Areas for improvement included, refrigerator temperature being out of range and not acted on, and an out of date medicine had been found. An action list was produced following the audit. However, during the inspection, we found that there was an ampoule of medicine in the theatre department that was out of date. We informed staff and this was immediately removed. At the unannounced inspection, we checked medicines at random and they were found to be in date.
- Medicines that may be required in an emergency were available on the resuscitation trolley, in a secure container and were in date.
- We found that medicine refrigerators and ambient room temperatures were recorded daily. However, there was no guidance attached to the checklist to inform staff what the acceptable limits were. We asked three members of staff what the parameters were and they were unsure. At the unannounced inspection, we found that guidance for staff had been implemented.
- Trained staff could supply or administer medicines according to locally approved and signed 'patient group directions'. These records were checked and were found to have been updated maintained and signed by staff.

Good

Surgery

Records

- There were care pathway documents that were used to record the patients' journey through their care and treatment at Blakelands Hospital. We checked six patients' care pathways and found that these were completed appropriately. The care pathways were in line with AAGBI guidance for day case and short stay surgery (2011).
- The care pathways incorporated a signatory list. This meant that staff completing the care pathway could be easily identified.
- Risk assessment screening questions were incorporated into care pathway documents, which prompted the clinician to complete more in-depth assessments, if an area of risk was highlighted. For example, the Malnutrition Universal Screening Tool to assess a patient's risk of malnutrition.
- The hospital used a paper based records system for recording patients' care and treatment.
- Patients' records were stored securely in a lockable trolley whilst in use on the wards, to maintain confidentiality.
- Staff at the hospital completed mandatory training regarding information security and compliance was 98% at September 2016.

Safeguarding

- The hospital had safeguarding policies and procedures available for staff on the intranet, which included details of how to manage suspected abuse and details of who to contact. It also provided a flowchart to guide staff should a patient be found to have had female genital mutilation.
- Staff we spoke with could tell us about what steps they would take if they were concerned about potential abuse of patients or visitors. They were able to describe different types of abuse and give examples of when they would escalate concerns.
- Staff at Blakelands Hospital were required to undertake mandatory training for safeguarding adults. The compliance at September 2016 was 98% (45 out of 46 staff completed) for safeguarding adults level one and 88% (23 out of 26 staff required completed) for safeguarding adults level two.
- Blakelands Hospital did not provide services for children. Safeguarding children level two training was completed by staff at the hospital. This was in three sections; A) recognition, B) response and C) record. Compliance with this training at the time of inspection was 52% (24 staff out of 46 completed) for parts A and B, and 72% (33 staff out of 46 completed) for part C. However, this meant that not all staff were up to date with relevant guidance to protect children associated with the adults they were caring for, from abuse.

Mandatory training

- There were systems in place for staff to complete mandatory training in a range of subjects. The topics covered included fire safety, infection control, manual handling and information security.
- Staff informed us that they had completed mandatory training, which was delivered mostly online.
- The theatre manager was responsible for ensuring that staff in the department attended their mandatory training. They demonstrated how they could check the status electronically via a training tracker.
- The matron maintained that the target for completion of mandatory training was 100%. This was achieved for equality, human rights and workplace diversity training for senior managers.
- Compliance with mandatory training by hospital staff that was above 90%, was achieved in customer service (96%), data protection (98%), emergency management and fire safety (96%), health and safety (96%), infection control (96%), information security (98%) and manual handling (91%).
- Compliance above 80% was achieved in workplace diversity (89%) sharps and blood borne virus (84%) and basic life support (87%).
- Please also see safeguarding section.

Assessing and responding to patient risk

- Blakelands Hospital was a day case service and did not have inpatient facilities, such as a ward. Therefore, in order to ensure that appropriate patients were treated at the hospital there was a patient exclusion list. For

example, patients with a high body mass index or those who had suffered a heart attack in the preceding six months were unsuitable to receive treatment at Blakelands Hospital.

- Patients had to complete a medical questionnaire before they attended for a procedure. Information about patients' past medical history, allergies, medicines taken and previous anaesthetic and surgery were included in the form. This helped to ensure that patients met the criteria for attending Blakelands Hospital for their procedure. This was also used to assess whether a patient needed to attend for a pre-operative check appointment prior to the procedure date. Pre-assessment was carried out in the outpatients department. Please see the outpatient and diagnostic imaging section of the report.
- The national early warning score (NEWS) was used to identify deteriorating patients. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored according to pre-determined parameters. We checked charts associated with six patients and found these to be completed appropriately. We saw that audits were carried out to check whether NEWS was recorded and calculated correctly. The results were 100% for September 2015. However, this was 82% when checked again in March 2016. Following this result, staff were reminded of the importance of recording the NEWS correctly. This meant there were systems in place to assist staff to identify patients who were deteriorating or at risk of deteriorating so they could be treated appropriately.
- During our inspection, a patient who was due for surgery became unwell. We saw that concerns were escalated in a timely fashion to medical staff, including the surgeon and the anaesthetist. They reviewed the patient and arranged for them to be monitored closely. When the patient was recovered, plans were made for further checks and the surgery was to be rebooked. This demonstrated that there were processes and procedures in place for when a patient was unwell.
- We observed patients undergoing endoscopy and before and after surgical procedures. The appropriate level of monitoring of patients vital signs was used including, oxygen saturation levels, blood pressure and monitoring.
- The hospital had a service level agreement (SLA) in place with a nearby NHS trust. This was for patients whose condition meant they need to be transferred for overnight care and observation. The SLA included responsibilities for key staff. For example, it was the consultant's responsibility to contact the NHS trust admitting consultant, to describe the procedure that had been undertaken and advice about the on-going care and treatment that the patient would require. However, this SLA did not cover transfer for critical care. This was discussed with matron for the hospital who explained that in the event of an urgent transfer being required for a patient, an emergency ambulance would be called for via 999.
- According to the AAGBI guidelines for recovery (2013), at all times there should be at least one member of staff present who is a certified Advanced Life Support (ALS) provider. We were told that there was not always a member of staff present in recovery area that had completed this course. We raised this with the senior management team during the inspection, they told us the permanently employed consultant anaesthetist was an ALS provider and there were more staff planned to undertake the training. At the unannounced inspection, we found there was an anaesthetist who was a current ALS provider (not involved with procedures) immediately available if emergency support was required. The matron and senior hospital staff had drafted an action plan following our inspection, which was shared with us. Actions included, review of the AAGBI guidelines, complete a risk assessment, review all staff current ALS status, identify staff for ALS training and book places. These actions were found to be complete at our unannounced inspection.
- We found that the staff were using the WHO five steps to safer surgery. We observed pre list safety briefing and checklists completed appropriately for surgery in theatre one. There was a safer endoscopy checklist in use for the endoscopy theatre. However, we observed inconsistencies in its delivery. There were three stages. First was 'sign in', followed by the 'pause' stage which involved final checks immediately prior to the actual start of the procedure and then the 'sign out' stage. We observed three endoscopy procedures and found that the checklist were not undertaken as three separate stages. We raised our concerns with the senior management team during the inspection and they told

us that they would investigate and address this. At the unannounced inspection, we observed that the safer endoscopy checklist was completed and staff were considering risks and ensuring that the correct patient was undergoing the correct endoscopy. However, we observed that this remained not being undertaken as three separate stages. Matron and the theatre manager explained that observational audits had taken place and would continue to be undertaken regularly to support the checklist process. We were not assured that the checklist was completed consistently in line with the three stages and noted that this had not been recognised prior to our inspection. This increased the risk of a patient safety incident occurring.

- The care pathway documentation used for patients undergoing procedures, included a checklist to be completed prior to discharge. This included that the patients observations were within normal limits, the wound site dressing was clean and dry, and the patient understood post-operative care advice. In line with AAGBI guidance for day case and short stay surgery (2011), the patient was advised not to drink alcohol, drive or operate machinery and was given a contact phone number for the first 24 hours.
- We were told and we observed that nursing staff called patients the day following their procedure, to check on their progress. This was guided by the care pathway documentation. This included questions and prompts for staff to check the patient's pain level, any problems with the wound, whether they were able to eat and drink or had any new health problems. This meant that any concerns could be addressed at an early stage and reassurance could be provided. For example, a staff nurse explained that consultants could be called for advice if required. This post-procedure check telephone call was also carried out on Sundays, if the patient had their procedure on Saturday. This was managed by the on call nurse for the service.

Nursing and support staffing

- Staffing for the theatre each day included an operating department practitioner (ODP), two 'scrub' registered nurses and a care support worker (CSW). For the endoscopy theatre, the planned level was two qualified nurses and a CSW. In the recovery area and admissions area (which were located together), there were two staff (qualified nurses or ODP). On the day of our inspection, we found that the actual staffing of the department met the planned staffing levels.
- Staff in the department usually worked shifts from 8am to 6pm. There were processes in place to either pay staff for extra hours worked or provide time off in lieu.
- The theatre manager was responsible for maintaining rotas for theatres. There was a paper rota and a master electronic system. The rota was planned each Wednesday in advance of the next week's activity. This meant that it was adapted to meet the needs of the service. However, it was acknowledged that staff might not know when they were working until short notice. This issue was noted on the hospital's risk register. We checked a sample of rotas during the inspection and planned staffing levels were met.
- The use of bank and agency for nurses working in the theatre department, was mainly higher than the average of other independent acute hospitals in the reporting period (July 2015 to June 2016), except for in July 2015 to September 2015 and June 2016, when it was lower than the average. The average rate was around 20%. In the six months ending April 2016, the rate for the theatre department at Blakelands Hospital had been from 26% to 48%. The theatre manager told us they employed bank and agency staff as required to ensure safe staffing levels.
- There were no bank ODPs or CSWs working in theatre departments in the three months ending June 2016. The use of bank and agency ODPs and CSWs were lower than the average of other independent acute hospitals in the same reporting period (July 2015 to June 2016), except for in August 2015 and November 2015, when it was higher than the average.
- In the three months ending June 2016, there were no unfilled shifts for the theatre department.
- The sickness rates for nurses working in the theatre department were mainly better than the average of other independent acute hospitals in the reporting period (July 2015 to June 2016). In the seven months ending June 2016, there had been no sickness for ODPs or CSWs working in theatre department.

Good

Surgery

- The rate of theatre registered nurse turnover (25%) was above (worse) the average of other independent acute providers that we hold this type of data for (15%) from July 2015 to June 2016. However, there was no turnover of ODP or CSWs in the same period.
- The service reported no current vacancies in the theatre department (June 2016).

Medical staffing

- Blakelands Hospital was a day case facility and therefore did not require the availability of 24-hour consultant led care. However, a staff nurse explained that consultants would stay until a patient had recovered and was available for advice if required. The on call nurse was provided with a mobile phone that had been pre-programmed with the consultant's contact details.
- The services of a resident medical officer were also not required. This meant that medical care was provided at consultant level at the hospital.
- There were 29 medical staff including, surgeons, physicians and anaesthetists employed or through practising privileges (PPs) agreement with the provider. The PPs status was routinely discussed at the medical advisory committee.
- The expectations of the consultant anaesthetist role had been recently updated and shared with the anaesthetists who held PPs with the hospital. It outlined that the anaesthetist role covered all areas of the hospital; including outpatients and that they may be called upon to assist with insertion of venous access, pain relief prescriptions and other general duties.
- The service also employed a consultant anaesthetist, who usually worked from 12pm to 8pm each weekday.

Emergency awareness and training

- Ramsay Health Care UK Operations Limited had a business continuity management policy. This was set at a corporate rather than a local level.
- In October 2016, there was a tabletop scenario, to test emergency response to a bomb threat at the hospital. The facilitator rated the response overall as satisfactory.
- Staff at the hospital completed mandatory training in emergency management and fire safety and compliance with this was 96% at September 2016.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We were provided with the local audit programme for Blakelands Hospital. This was set corporately by Ramsay Health Care UK Operations Limited. The programme ensured that different aspects of care and treatment were checked during each monthly audit. The aspects included medical records, consent, pre admission and discharge care, medicines management, World Health Organisation (WHO) safer surgical checklist and infection prevention and control.
- The audits were based on national guidance including Association of Anaesthetists of Great Britain and Ireland (AAGBI), the Department of Health, National Institute for Health and Care Excellence (NICE), the Royal Colleges and the General Medical and Nursing and Midwifery Councils.
- The audit programme was reviewed at the clinical governance meeting to monitor progress.
- We found that the audits were completed as per the schedule. At the bottom of each completed audit, staff were prompted to note what actions were required to address any areas of weakness that an audit had highlighted. We noted that many of the actions included reminding staff to complete documentation. We saw that the results of the monthly audit results were also shared at meetings, including the medical advisory committee (MAC).
- We saw that there had been a declining performance in the audit of the documentation of veno-thromboembolic (VTE) risk assessments. The audit for June 2016, showed 59% compliance. The risk assessments were in place, with areas of the documentation needing to be improved. This was discussed at the MAC meeting in June 2016. However, it was unclear from the minutes what actions were taken

to improve this result. We reviewed the pre-assessment VTE audit for November 2015 that had an action for The February and May 2016 re-assessment VTE audits had no follow up comments or actions noted. The minutes for June 2016 recorded that compliance with pre-assessment VTE had declined from 97% in November 2015 to 59% in May 2016. The action from the MAC meeting was to We requested an action plan from the provider. This was provided and it included raising awareness and completion of documentation appropriately. 15 hospital staff attended a clinical study day in August 2016 and topics included aspects of VTE management and prevention, such as anti-embolic stockings. There was a re-audit carried out in August 2016 and compliance had improved to 85%. There were also on-going actions to complete.

- Blakelands Hospital were contributing to some national audits. See patient outcome section.
- We saw there were care pathway documents used at the hospital. Care pathways are a way of setting the best practice to be followed in the treatment of a patient with a particular condition or a certain procedure. There were four care pathways in use, day case pathway under local anaesthetic (LA), day case pathway under general anaesthetic (GA), cataract care pathway under LA and an endoscopy pathway under LA or sedation. The care pathways contained prompts to guide staff to comply with evidence-based care at each stage of the patient's journey. For example, the day case pathway for patients having a GA, included the predicted American Society of Anesthiologists (ASA) scoring, which is a system for assessing the fitness of patients before surgery.
- The provider informed us that all implants including screws, meshes, cataracts and breasts, were recorded on the surgical implant register, which was a corporate database. The hospital had completed two breast augmentation procedures and these were in the process of being added to the National Breast Register.
- We saw that the hospital had local policies and procedures in place to guide staff. Those that we accessed were within review date and relevant.
- The hospital had systems in place to provide care and treatment in line with best practice guidelines (NICE CG50: Acutely ill patients: recognition of and response to acute illness in adults in hospital). For example, an early warning score system was used to alert staff should a patient's condition start to deteriorate.
- The endoscopy service at Blakelands Hospital was Joint Advisory Group (JAG) accredited. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver the service against recognised patient centred standards.

Pain relief

- We saw that the presence and severity of patient's pain was assessed and documented on the observation charts. Pain relief was provided as prescribed.
- The care pathways that were in use, prompted staff to assess whether patients were comfortable and had appropriate pain relief in the immediate post procedure phase and before a patient was discharged home.
- Patients received a call the day following their procedure. Part of this check was to ask whether the patient was in pain and if pain relief was keeping them comfortable. This was prompted by care pathways, for example the surgical day case pathway under GA.
- The monthly patient satisfaction surgery showed that for May and June 2016 100% of patients' feedback that staff did everything to control their pain.

Nutrition and hydration

- There were no catering facilities within the hospital as it was a day case hospital.
- Staff informed us that patients could be offered snacks and beverages when required, such as tea and biscuits.
- Patients were required to fast in preparation for procedures. Pre-operative fasting guidelines used by Blakelands Hospital, were aligned to the recommendations of the Royal College of Anaesthetists. The fasting times were no solid food for six hours and clear fluids up until two hours pre procedure. Patients were advised of this pre-admission and were called usually the day before surgery to give an approximate time of their surgery. However, this was not formally audited to see how often these fasting times were achieved.

- Blakelands Hospital was a day case only facility and therefore did not require a catering department. When sufficiently recovered from procedures, patients were offered cold or hot drinks and biscuits.
- Risk assessments regarding nutritional status were not routinely performed, unless they were indicated through the screening questions on the care pathways.

Patient outcomes

- The hospital participated in some national audits to monitor patient's outcomes, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme. However, due to small numbers of applicable procedures undertaken at Blakelands Hospital, the England adjusted average health gain could not be calculated. The generic health status measure index (EQ-5D) following groin hernia surgery indicated 36% of patients had improved health status and 32% had worsened (out of 28 modelled records). The Visual Analogue Scale (component of the EQ-VAS EQ-5D) indicated 32% of patients reported as improved and 46% as worsened following the surgery.
- There was one unplanned transfer of a patient from July 2015 to June 2016. This was for a patient that required specialised services and was requested to attend a nearby NHS trust. This was not an emergency transfer.
- The provider reported no cases of unplanned patient readmission within 28 days of discharge and no cases of unplanned return to the operating theatre from July 2015 to June 2016.

Competent staff

- We saw that new staff to the hospital undertook an induction. This was guided by an induction package file. This mapped out both the corporate induction and local orientation. It progressed to include competences that needed to be completed, according to role. We checked a new member of the team's folder and found it to be comprehensive and well completed.
- Each year staff were required to have a meeting to discuss their performance and identify areas for development in the following year. The provider reported that all of the staff at the hospital had received an appraisal in the year 2015 and 68% have completed their appraisal for 2016. We noted that none of the registered nursing staff employed by Blakelands Hospital had an appraisal in the first six months of 2016.
- All of the theatre nurses and operating department practitioners (ODPs) working in the department were reported to have their professional registration validated. There were processes in place to ensure these were checked.
- There were 29 medical staff employed or practicing under rules and privileges for the provider, all of which 29 had their registration validated in the 12 months ending June 2016.
- Staff received training so they could respond and treat a collapsed patient. A variety of clinical staff (16) at the hospital, including registered nurses, ODPs and care support workers had attended an immediate life support course in the nine months ending September 2016.
- The matron told us that the provider booked sales representatives from different companies to teach and train staff on certain equipment. For example, a representative from an electrocardiography machine company had attended in September 2016 and provided training to staff about how to effectively operative the equipment.
- The provider had a policy to guide staff about clinical supervision at Blakelands Hospital. This outlined responsibilities at each level including the matron's role. However, the policy was past its review date of January 2016.
- The hospital was looking at providing laparoscopic (keyhole) surgery in the future. In preparation for this, two staff were undertaking surgical first assistant training.

Multidisciplinary working

- We observed that the team worked well together at Blakelands Hospital. It was a small facility and this assisted with maintaining good multidisciplinary working.

Good

Surgery

- There were service level agreements in place for infection control support advice and training, provision of chaplaincy and transfer of patients requiring overnight stay at a nearby NHS trust.
- Following discharge from hospital, information about a patients care and treatment provided, was sent to the patient's GP. The care pathways used to document care and treatment at Blakelands Hospital, guided staff to consider a patient's discharge requirements at the pre admission stage. One example was, ensuring that an adult would be with the patient for the first 24 hours following discharge.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment. Staff had access to patient records, which were paper based.
- Computers were available in the ward and theatre areas. Staff were able to access information, including policies and procedures via the computers. The matron told us that they encouraged staff to read new policies and staff were asked to acknowledge they had read policies by signing a declaration.
- Following discharge from hospital, information about a patients care and treatment provided, was sent to the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During the inspection, we checked consent forms in six patient's records. We found that they had been completed appropriately and signed by the patient and the consultant.
- We observed that the consent form was checked with the patient and by staff prior to the surgery or procedure taking place.
- We saw that consent was part of the local audit programme. There were four audits carried out from September 2015 to June 2016 and compliance was 94% to 99%.
- Ramsay Health Care UK Operations Limited had polices in place to guide staff regarding Deprivation of Liberty Safeguards and Mental Capacity Act 2005. They included mDeprivation of Liberty Safeguards and the Mental Capacity Act 2005.
- Staff at the hospital had received training about Deprivation of Liberty Safeguards and Mental Capacity Act 2005 during a clinical update day held in September 2016.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- We observed that staff at Blakelands Hospital respected patients' privacy and dignity. Gowns were provided when patients walked to the operating theatre to ensure their dignity was protected. Once patients were taken to the recovery, staff closed curtains to ensure their privacy.
- The 13 patients and relatives who we spoke with were complimentary of the staff and the hospital.
- We observed staff interacting with patents in a professional and compassionate manner throughout the hospital.
- Patients told us and we saw that staff were kind, respectful and always introduced themselves.
- A patient contacted the reception staff by telephone because they were having trouble finding the hospital. We heard the receptionist giving directions in an informative and sympathetic way. The receptionist told the patient not to worry about arriving late and to remain calm.
- The hospital submitted data to the Friends and Family Test. This is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across the NHS.
- The monthly patient satisfaction surgery showed that for May and June 2016 100% of patients' feedback that they had received a friendly welcome.
- We spoke with a visitor who had surgery at Blakelands Hospital previously. They had found the whole

experience positive and said they had been treated very well. They had received a call from the staff the day before and post-surgery. They felt well informed and treated kindly.

- Patients told us they were 'really pleased with the care' and 'impressed with the clean facilities'.
- The patient led assessment of the care environment (PLACE) audit 2015 score for ensuring patients were treated with privacy and dignity was 83%, which was worse than the national average of 86%.

Understanding and involvement of patients and those close to them

- Patients told us they had found that everyone had been helpful and kind and they had been kept well informed through every stage of their care and treatment.
- Patients told us they had been given opportunities to discuss their surgery and the risks and benefits involved with their consultant, and felt actively involved in decision-making.
- We observed a patient being discharged. Staff were patient and the aftercare was explained thoroughly.
- A relative we spoke with in the waiting room had been invited to attend the consultation with the patient's consent.

Emotional support

- We observed patients undergoing endoscopy and before and after surgical procedures. Staff were patient and supportive at all times. They showed an understanding of the anxiety that patients may be experiencing before a procedure.
- Staff ensured that the atmosphere in the department was calm. One patient particularly told us how much they had appreciated this.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Blakelands Hospital offered a day case only service for elective procedures and minor surgery. Therefore, it did not have inpatient facilities. The premises had been purpose built to deliver elective surgical services to patients. A local clinical commissioning group commissioned Blakelands Hospital to provide surgical services. There were also self-pay patients treated at the hospital.
- There had been as increase in the number of patients referred, for endoscopy in particular and the service was adapting to meet demand. For example, there had been trial runs of lists taking place on Saturdays.
- The hospital had a large waiting area, which was comfortable and although busy, there were enough seats for all patients and visitors.
- There was a chargeable drinks machine and a free water dispenser in the waiting area.

Access and flow

- Blakelands Hospital offered elective procedures and did not have inpatient facilities. In order to ensure that the appropriate patients were treated at the hospital there was an exclusion list. This list reduced the risk of patients who may need overnight care attending Blakelands Hospital. Patients had to complete a medical questionnaire before they attended for a procedure. This helped to ensure that patients met the criteria for attending Blakelands Hospital. This was also used to assess whether a patient needed to attend for a pre-operative check appointment prior to the procedure date.
- Patients were assessed for their suitability to be treated within the hospital at pre-assessment or their first consultation. The local NHS clinical commissioning groups provided criteria for patient selection. For example, patients with a body mass index of over 40, could not be safety treated within the service.
- Most patients we spoke with told us they received a call from staff the day before their appointment or procedure. The patients were asked over the telephone if they were fit and well and still planned to attend their appointment.

Good

Surgery

- Ramsay Health Care UK Operations Limited had a policy to guide staff at Blakelands Hospital regarding waiting lists and the management of patients accessing NHS treatment.
- The hospital achieved 100% of NHS patients treated within 18 weeks of referral from July 2015 to June 2016. One patient told us how they had been very pleased with the speed of the process. They said it has been very quick from the referral to having the procedure.
- Blakelands Hospital had two theatres. Theatre one was used for surgical procedures. In order to allow sufficient time for recovery and discharge, procedures that required a general anaesthetic were started no later than 4pm each day.
- Theatre two was used as an endoscopy suite. After 5pm there were no procedures carried out that required sedation. This was to allow the safe discharge of patients into the early evening.
- The average length of patient stay at Blakelands Hospital was monitored and reported to be less than four hours (September 2016).
- < >he hospital cancelled 39 procedures for a non-clinical reason in the 12 months ending June 2016. All of the patients were offered another appointment within 28 days of the cancelled procedure.
  Patients had to complete a medical questionnaire before they attended for a procedure. This included sections for any special dietary requirements, visual or hearing impairments, learning disability or whether an interpreter will be needed. This meant that staff would have information to make any necessary arrangements to meet an individual's needs before they attended for a procedure. Staff told us that interpreters could be arranged to attend the hospital.
- At the reception desk of the hospital, there were flashcards available to assist people with a learning disability or communication difficulty.
- The clinical departments and waiting room were all on one floor and accessible to people who used wheelchairs or other forms of mobility aids.
- The latest patient led assessment of the care environment (PLACE) audit 2015 scored 100% for patients with a disability and 98% for those people living with dementia.
- There were several leaflets in the waiting areas available to patients. These included information about procedures, treatments and the hospital. These were all printed in English. Translation services were available and could be accessed if needed.
- Patients received instructions for what to do on the day of their appointment including, the name of the procedure, fasting instructions, advised to shower and wash hair evening before, medicines instructions, and name of their nurse and doctor. This was clearly presented on a large font printout.
- We spoke with staff during the inspection, who were able to discuss how they would meet a patient's individual needs. For example, to enable a patient who had poor eyesight to receive the appropriate information about their planned procedure and post-operative instructions, staff arranged for this to be emailed so that they could put it into software which 'read' the text out loud.

Learning from complaints and concerns

- In the last 12 months ending June 2016, the hospital received 19 complaints. Complaints and learning were discussed at meetings including, clinical governance, head of department and medical advisory committee meetings.
- We found that information, such as leaflets to guide patients and visitors to how to complain about the service were not clearly on display in the main waiting room. We informed the senior management team of this during our inspection. At our unannounced inspection, we found that the complaints procedure leaflet was readily available.
- Customer service training was mandatory for staff at the hospital and compliance with this training was 96% at September 2016.
- Most of the patients said they knew how to make a complaint and that they would contact the hospital directly.
- The monthly patient satisfaction survey showed that for May and June 2016, 78% and 89% of patients fed back that they had received copies of letters between the hospital and GP. The matron told us that from this feedback a system had been implemented to ensure letters were addressed to all parties required.

Good

Surgery

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Vision and strategy for this core service

- Blakelands Hospital is part of Ramsay Health Care UK Operations Limited, which had principles and values called 'the Ramsay way'. Ramsay Health Care UK Operations Limited stated they were committed to integrity, ownership, positive spirit, innovation and teamwork. Staff were aware of the Ramsay corporate group values.
- The vision and strategy for Blakelands Hospital was in the operational plan and framework. The framework was based on the six Cs, which are Care, Compassion, Competence, Communication, Courage and Commitment (NHS 2012). There were also six themes to the framework and these included 'putting patients at the heart of what we do, people are our most important attribute, quality should underpin everything we do, and being as cost effective and efficient as possible'.
- Understanding of the strategy and vision was clear at a senior level. However, this was less clear at a departmental level.

Governance, risk management and quality measurement (and service overall)

- Blakelands Hospital had a governance structure in place. The key meetings were the medical advisory committee (MAC) and the clinical governance committee. The MAC provided a forum for communication between the senior management team and the clinical governance committee. We looked at minutes of these meetings and they included discussions about complaints, incidents, new national guidance and audit programme results. The meetings took place at regular intervals and appeared well attended.
- The hospital had a risk register, which contained clinical and non-clinical risks to the provision of services. Risks were held on an electronic system. We saw that this had been reviewed at meetings. However, it was described as work in progress in the clinical governance meeting in July 2016.
- We found that the risk register was not always used as a tool to manage risk actively at a departmental level. There were risks that were highlighted during the inspection that were not included in the risk register. For example, there was not a service level agreement (SLA) for patients to be transferred for urgent emergency care. This was discussed with matron who acknowledged that the SLAs needed review and explained that in the event of an emergency transfer being required for a patient, an ambulance would be called for via 999. In addition, the variable compliance with veno-thromboembolic risk assessment completion was not included as a clinical risk to patient safety. This meant actions that had been taken to reduce risks, had not been captured centrally by this governance process.
- We found that not all surgical site infections that were reported had an associated root cause analysis report. Therefore, we could not be assured that the organisation was investigating and learning from all reported surgical site infections.
- We observed inconsistencies in the way the World Health Organisation (WHO) safer endoscopy checklist was used. Particularly that it was not undertaken as three separate stages. Matron and the theatre manger explained that observational audits had taken place and would continue to be undertaken regularly to support the checklist process. We noted from minutes of meetings that the WHO safer surgical checklist had been implemented in November 2015 but its use was not fully embedded.
- We found that leaders of the service had not recognised the lack of robust processes in place. For example, we found there was no checking procedure for the difficult airway trolley.
- Senior staff were aware of the National Safety Standards for Invasive Procedures (NatSSIPs September 2015). The NatSSIP standards include a set of recommendations that help provide safer care for patients undergoing invasive procedures. Each clinical organisation were required to draft local safety standards for invasive procedures. The provider shared an action plan to

progress towards these standards. Leads had been allocated, it had been discussed at clinical governance meetings and staff in departments, including consultants with practising privileges, had been made aware. However, human factor training, which is an important part of the safety standards for invasive procedures, had not been provided. Human factor training looks at the relationship between human beings and the systems with which they interact. A failure to apply human factors principles is a key part of most serious patient safety incidents in healthcare. This training was identified on the action plan to be arranged.

- The provider informed us that all implants including screws, meshes, cataracts and breasts, were recorded on the surgical implant register, which was a corporate database. The hospital had completed two breast augmentation procedures and these were in the process of being added to the National Breast Register.
- We reviewed a random sample of three staff files. We found that recruitment checks had been made, such as (. We were told that the organisation policy was to obtain two references per staff member recruited. However, there were only one for each of the staff files we looked at. This meant that part of the recruitment process did not follow policy.

Leadership / culture of service

- The senior management team (SMT) led the hospital. This consisted of the general manager, matron, theatre lead, outpatient department lead, financial lead marketing lead and administrative lead. The general manager provided overall leadership and the matron provided the clinical leadership within the hospital. The general manager had been at Blakelands Hospital since 2015 and the matron was new in post. The SMT was therefore a new team, were open, and honest about some areas at the hospital were 'work in progress'. Each SMT member was responsible for a multidisciplinary team who in turn provided the network for the hospital to function. To support the network there was a governance structure for health and safety, clinical governance, infection control and MAC. Overall, the hospital was part of a regional group with a senior regional team for the company.
- Each service area, for example outpatients, had an allocated head of department. These included a theatre manager, an outpatient's lead and physiotherapy and radiology managers. We saw from minutes that there were regular (monthly) head of department meetings.
- Leaders were part of the relevant Ramsay Health Care network groups. For example, matrons would meet as a group to share best practice.
- Staff told us that the general manager and the matron were visible and approachable. They also told us that recent staff appointments, including the matron and outpatients lead, had made a positive improvements to the hospital. Staff also told us that previously they were often working long hours without proper rest breaks. The situation was described as having improved since the new leads had been employed.

Public and staff engagement (local and service level)

- Staff told us that they were invited to attend team meetings. However, they were unsure whether there were minutes recorded, as they had not seen them. We were provided with examples of department level meeting minutes. They were brief and appeared to be used mainly to share information with the team. It was unclear whether staff found them a useful forum to raise issues, as this level of detail was not included.
- Each year the hospital had an assessment carried out by patients called the patient led assessment of the care environment (PLACE).
- Staff told us that a patient focus group had been implemented to improve services at Blakelands Hospital. The first patient participation group meeting took place in July 2016 (deferred from May 2016 due to illness). Minutes of this and the second meeting (September 2016) showed discussions including PLACE assessments and safety messages.
- Blakelands Hospital undertook staff engagement survey in 2016. The results that compared favourably to other organisations in the Ramsay corporate group included, that 90% of staff agreed that they would recommend the Ramsay Health Care group to family and friends who needed the services. In addition, 100% of staff indicated that they understood the impact that their work had on delivering excellent patient care. However, there were areas that scored lower (worse) than the other

organisations in the Ramsay corporate group. These included 32% (compared to 34%) of staff felt that their pay was fair in comparison with people in similar jobs in other companies and 52% (compared to 58%) felt that Ramsay Health Care promoted a healthy work and home life balance.

Innovation, improvement and sustainability (local and service level)

- In preparation for our inspection there was an internal 'mock' inspection carried out in November 2015. The provided shared the mock inspection report with the CQC team. There were many areas highlighted in the report that were found to require improvement and a detailed action plan was developed to address these. The general themes to the findings were that there was a lack of evidence and formalisation of the quality work that was undertaken. In addition, that it was often unclear that the loop had been closed when actions were taken to change or improve practice. Although we saw evidence of progress, there were areas related to actions that required improvement. For example, we found that actions taken following audits or incidents were often centred on reminding staff to complete documentation rather than addressing any underlying contributory factors.
- Commissioning for Quality and Innovation (CQUINS) were set by the local clinical commissioning group to encourage improvement. Those that were set for year 2015/16 related to hand decontamination and consent. Both CQUINS had been met.
- The provider was asked to submit details of areas they required to improve. These were to achieve a better staff skill mix to meet the increased demand for services and to provide access to blood transfusion on site and phlebotomy service supported by a local NHS trust.

Good

Outpatients and diagnostic imaging

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

Information about the service

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good for outpatients and diagnostic imaging.

Incidents

- Staff we spoke with understood their responsibility to raise concerns, to record safety incidents and near misses and to report them.
- The hospital used an electronic incident reporting system to record incidents. Staff we spoke with understood this mechanism of reporting incidents and gave examples of incidents they had reported and of how feedback was received.
- From July 2015 to June 2016, there had been 22 clinical incidents within outpatient and diagnostic imaging services reported. The rate of clinical incidents reported was similar to the rate of other independent acute hospitals we hold this type of data for.
- Four non-clinical incidents within outpatient and diagnostic imaging services were reported between July 2015 and June 2016. The rate of non-clinical incidents reported was similar to the rate of other independent acute hospitals we hold this type of data for.
- We saw evidence to show staff completed radiation reviews annually. There had not been any incidents relating to radiology in the reporting period.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of the duty of candour regulation, to be open and honest with patients and relatives when things went wrong and to offer an apology.

Cleanliness, infection control, and hygiene

- There was a service level agreement with a local NHS trust that provided infection control and prevention services to the hospital. The service provided included a telephone advisory service five days a week, where advice could be sort from both a microbiologist and the trust infection control team. Out of hours, there was

access to a microbiologist on call. The external provider also provided advice on infection outbreaks, inoculation injuries and provided twice-yearly infection control teaching sessions for hospital staff.

- The hospital had a strategic action plan around infection prevention and control 2016 to 2019 which included maintaining 95% compliance with infection control training and achieving 90% compliance with environmental and hand hygiene audits. These targets were achieved within the service. For example, the hand hygiene audit for April 2016 showed a 99% compliance with procedures.
- All areas visited were visibly clean, with the appropriate 'I am clean' stickers on clean equipment.
- Diagnostic rooms were cleaned daily and only radiology staff cleaned the equipment to ensure the safe maintenance of the equipment.
- The patient toilets in all outpatient areas were clean and fit for purpose.
- Staff informed us that they were responsible for cleaning the outpatient's examination couches and work surfaces between each patient. If a patient with an infection, for example, influenza or MRSA was seen; staff confirmed that housekeeping staff would clean the room. We saw evidence of cleaning schedules and checklists during our inspection. The hospital conducted a monthly infection control and environmental audit, data from May 2016 showed that there was 98% average compliance across all sections of the audit. However, there was 82% compliance with sharps management. This was mainly due to inappropriate rubbish placed in sharps bins instead of in the correct clinical waste bins. The actions following the audit were to arrange an external sharps audit and to remind all staff about correct clinical waste disposal. During our inspection, we found that all sharps disposal bins were labelled correctly were not overfilled and did not appear to contain in appropriate waste.
- Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Bins were foot operated and not overfilled.
- The hospitals 2016 patient led assessments of the care environment (PLACE) indicator for cleanliness was 100%.
- Personal protective equipment (PPE), such as gloves and aprons, were used appropriately and were available in sufficient quantities.
- Hand hygiene gel was available in both the outpatients and diagnostic imaging department. Hand washbasins were also available in outpatient consulting rooms.
- We observed staff complying with 'bare below the elbow' policy across all areas visited.
- All patients attending the pre-assessment clinic were swabbed for MRSA and referred to their GP if results were positive and treatment was required. Patients with positive MRSA results were not admitted for their surgery until they had been swabbed and three negative swabs had been received.
- Any samples for testing, for example wound swabs, were sent directly to a national provider with whom the hospital had a service level agreement. Staff telephoned to book the sample in for testing, and then the sample was placed in a special postable sample bag. A copy of the test request was sent with the sample and a copy was retained in the patient's notes. The samples were collected once daily by a mail delivery service. Results of tests were telephone through to the outpatients department, and followed up by a fax.
- Blood spillage kits were available to staff in the outpatients area if needed. Staff were able to describe what actions they would take in the event of blood spillage or in regards to decontamination following a patient with a communicable disease.

Environment and equipment

- The outpatients department was appropriate to meet the needs of the service with five clinic rooms and a reception area. There was sufficient equipment to maintain safe care.
- Resuscitation equipment for use in an emergency was regularly checked, and documented as ready for use.
- Equipment had safety test stickers with appropriate dates. This meant that there were procedures in place to ensure the maintenance and use of equipment kept patients safe from avoidable harm.

Good

Outpatients and diagnostic imaging

- The outpatient's reception area was open plan and well lit. There were adequate seating arrangements within the waiting area and no patients or relatives were standing.
- The imaging department had three changing cubicles. There was no separate male and female area.
- We saw evidence that the equipment in the diagnostic department was maintained and external engineers were used for specialist equipment. Lead aprons were tested annually for suitability for use. We saw records to demonstrate their maintenance.
- Some of the equipment within the diagnostic department was over 10 years old. However, this was on the hospitals risk register, and a regular maintenance programme was in place.
- The outpatient manager told us that new equipment was provided when necessary. The department had recently purchased new electrocardiography machines and new chairs for the waiting area after submitting a business case to the finance department.
- The diagnostic department had clear guidelines on which specialised PPE should be used for specific procedures. For example, lead gowns protected staff members from radiation exposure.
- Annual radiation protection audits were performed. We saw the audit completed in April 2016 but found there were no actions from the audit. The radiology manager told us that if actions were required after audit they were escalated through the clinical governance committee.
- The diagnostics imaging department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to. It was the responsibility of the radiation protection supervisor (RPS) to supervise work and observe practices to ensure compliance with these regulations and we found the service was complying with the regulations
- The hospital 2016 PLACE indicator for condition appearance and maintenance was 100%.

Medicines

- The pharmacy service was outsourced. The external service provided a pharmacy technician each week and conducted monthly medicine audits.
- There were no controlled drugs or intravenous fluids stored in the department. Medication that was administered in some clinics, was stored securely, for example, eye drops. Although staff reported this was rare, they could access other medication if necessary to meet the needs of patient attending the department. The appointment system encouraged patients to bring their own medication with them, and on most occasions patients were not in the department long enough to require additional medicines.
- The radiology department performed plain film imaging and ultrasound examinations. Therefore, the department did not store any medication, such as contrast medium.
- Temperature checks were completed on a daily basis where medication was stored. The hospital had recognised that there was a risk to medication stored in the pre-assessment consulting room. An air conditioning unit had been supplied in order to maintain the required temperature in periods of hot weather. The risk register reflected that when temperatures reached above 25 degrees there was a risk to the stability of medicines and that this should be escalated. However, there were no guidelines available to staff within the department on minimum and maximum temperatures.
- Prescription pads were stored securely within the pre-assessment outpatient's room to prevent theft and abuse. Staff kept a record of the serial number of all prescription sheets used.

Records

- Outpatient notes were stored securely in locked cabinets within the department.
- Staff we spoke with told us that patient notes were always available for appointments.
- We reviewed three sets of notes for patients attending an outpatient appointment. Referral letters, information about procedures undertaken and results of investigations were available.

- At the end of clinics, patient notes were returned to medical records were they were securely stored.
- Results from the medical records audit conducted from in July 2016 showed that 97% of medical records were completed appropriately. Audit results and actions were shared with all staff through team meetings and staff notice boards.

Safeguarding

- Staff received training and had a good understanding of their responsibilities in relation to the safeguarding of vulnerable adults. Training records showed that 100% of outpatient and diagnostic staff had completed adult safeguarding level one training, as per the Ramsey health: Safe Guarding Adults at Risk of Abuse or Neglect – CN037.
- There was named safeguarding lead who was the hospital matron and this information was displayed on various staff notice boards. Staff we spoke with confirmed action they would take if they had a safeguarding concern; they said that they would initially report their concern to the outpatient's manager and in their absence the matron.
- Nursing staff reported limited experience and exposure to patients with capacity or safeguarding concerns, as patients with these concerns were unlikely to be referred to the service. However, they were able to describe the relevant consent and decision-making requirements in place to protect patients and the actions they would take if they were concerned about a patient's capacity.
- There had been one adult safeguarding concern raised from the department between June 2015 and July 2016. This occurred in January 2016, where staff followed the appropriate procedures and informed the relevant authorities.

Mandatory training

- Training data showed that 100% of staff were complaint with mandatory training. Topics covered by mandatory training included, fire, infection control, and health and safety.
- Managers in the department told us that completing mandatory training was linked with staff pay rises. Therefore, if individual staff failed to complete training as expected, it had financial consequences.
- Staff we spoke with told us that they could access the hospital mandatory training system from home, which they found very helpful.

Assessing and responding to patient risk

- Pre-operative assessment is a clinical risk based assessment where the health of a patient is appraised to ensure that they are fit to undergo anaesthetic and therefore the planned surgical operation. It ensures that patients are fully informed about the surgical procedure and post-operative period and can arrange for admission, discharge, and post-operative care at home. The pre-operative clinic was nurse led. All patients undergoing a surgical procedure were triaged, and received either a face-to-face appointment or telephone appointment. Where necessary patients were referred to an anaesthetist, for example, if any clinical concerns were identified during the pre-operative assessment.
- Patients were sent a medical questionnaire to complete and return to the department before their pre-operative appointment.
- Pre-operative tests were completed in line with National Institute for Health and Care Excellence (NICE) guideline NG45: Pre-operative tests for elective surgery. The department did not have phlebotomy services at the time of inspection, therefore, patients were sent back to their GP with a blood request form to have their bloods taken. Clinic staff communicated with individual GP services to obtain blood test results. The hospital had recognised that this could potentially cause delays for patients and had planned to train outpatient nurses to take blood. Staff we spoke with had had confirmation of training dates. It was unclear at the time of inspection what arrangements had been made for the actual testing of the blood samples, for example, who the hospital had negotiated a service level agreement to establish which laboratory blood would go to in the future when staff were trained.
- Patients were assessed for their appropriateness for surgery using the American Society for Anaesthesiologist (ASA) physical status classification. This is a nationally recognised system for assessing the

fitness of patients before surgery. For example, ASA1 meant the patient was healthy and ASA2 meant that the patient had mild systemic diseases. This was recorded in the patient's pre-assessment record.

- Staff were knowledgeable about what actions they would take if a patient became unwell in the outpatient and diagnostic imaging department. This included putting a call out for medical assistance, which meant that staff holding the emergency bleeps would be alerted to attend the department.
- The hospital had a cardiac arrest and medical emergency team identified each day. The allocated team were responsible for carrying the emergency bleeps and responding to arrest calls. The team attended a huddle when they commenced their working day and their role within the cardiac arrest and medical emergency team was allocated. For example, a team member was identified to lead the team and a team member was identified for managing the patient's airway. This ensured that each team member knew their role to avoid confusion and ensure that patients received timely and coordinated care.
- The imaging manager told us that all patients were asked if they had undergone a recent x-ray. If the x-ray was applicable to the appointment, the image would be obtained to prevent the risk of over exposure to radiation.
- The department had clear guidelines on who was entitled to make a request or referral for diagnostic imaging in accordance with IR(ME)R.
- There were clear signs and lights in the radiology department informing people about areas and rooms where radiation exposure was taking place.

Nursing staffing

- In the outpatients department there were three registered nurses on duty and the outpatient manager. There was sufficient staffing to enable the delivery of patient care and treatment. Actual and planned staffing numbers were displayed
- The outpatient manager was responsible for ensuring that staffing levels were appropriate for all clinics. There were weekly workforce planning meetings to discuss staffing requirements to meet outpatient department demand. The hospital used an electronic health roster that provided a consistent effective approach to their workforce management; it aligned staffing with service demand.
- Staff worked 12-hour shifts and at the time of inspection, there was no daily huddle before clinics commenced to discuss allocation of staff or any issues. However, the new outpatient department manager told us that they had plans to introduce a morning briefing for outpatient staff within the next few months.
- Nursing staff within the outpatients department supported consultant led clinics, provided nurse led pre-assessment clinics and nurse led wound clinics. Each member of nursing staff had the skills and knowledge to provide any of these services to patients.
- In July 2016, the nursing vacancy rate was 0.8 whole time , giving the service a vacancy rate of 16%. The service used bank and agency staff to fill gaps in the rota. During April to June 2016, the bank and agency usage was 27% which when benchmarked against other independent acute hospitals in England was worse than average.
- The senior management team had recently advertised for a radiographer for the service but the position was not filled. Therefore, the radiology department was staffed by radiographers rotating from another Ramsay Health Care UK Operations Limited hospital to cover the service at Blakelands Hospital. Staffing levels met service demand.
- The full time permanent physiotherapist employed by the hospital was on maternity leave and therefore, the physiotherapy department was staffed by one agency physiotherapist. This was sufficient for the level of service provided.

Medical staffing

- Medical staff were predominantly employed by other organisations (NHS organisations) in substantive posts and had practising privileges to work at Blakelands Hospital. A practising privilege is defined as 'permission to practise as a medical practitioner in that hospital'. There were 29 doctors who had practising privileges at the hospital.
- Consultants had planned clinics and attended the department on set days and set times.

Good

Outpatients and diagnostic imaging

- Consultants could be contacted by telephone, e-mail or via their secretaries to offer advice to staff if they were not present in the department.
- There was no resident medical officer employed by the service. This is because the service provided a day surgery and outpatient service only.

Emergency awareness and training

- All staff within the department had completed emergency management and fire safety training.
- Staff we spoke with had been trained in intermediate life support and participated in the hospital emergency team. This meant that all staff were able to respond to a medical emergency.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected effective but it is not rated for outpatients and diagnostic imaging services.

Where our findings on surgery also apply the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section.

Evidence based care and treatment

- Patient's care and treatment was planned and delivered in line with evidence-based guidelines. For example, the service used care plans and patient pathways for specific procedures.
- Staff were able to access national and local guidelines via the hospital intranet.
- Policies were based on national guidance, for example Department of Health guidance. We saw an example of a policy for hand hygiene, which was in date and referenced a 2012 Department of Health quality statement about
- Policies were regularly reviewed to ensure that they were aligned to best practice guidance.
- Audits completed established compliance against national guidance. For example, the
- The diagnostic imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross-referenced to national audit levels and if they were found to be high, a report to the radiation protection advisor would be made.

Pain relief

- None of the patients we spoke with required pain relief at the time of or inspection.
- During pre-assessment patients who had potential pain management issues were identified and referred for an anaesthetic review. This meant that the anaesthetist could discuss issues with patients and pain management can be tailored to meet individual needs.

Patient outcomes

- The hospital local audit schedule was comprehensive and included prescribing, medical records and hand hygiene audits.
- The imaging manager confirmed that annual audits radiation protection audits had been carried out. For example, dose audits, annual audits of lead protection aprons and laser equipment and usage audits. We reviewed the audit results from the most recent audits all were in 2016. There were no recommendations made as a result of the audits. This meant we could not be assured appropriate actions and learning was identified as a result of audits.
- The diagnostic imaging department did not participate in the Imaging Services Accreditation Scheme or Improving Quality in Physiological Services.

Competent staff

- All staff working within outpatients, diagnostic imaging and physiotherapy services had an up to date appraisal where training needs were identified and objectives set.
- All new staff underwent a corporate and local induction and were supernumerary until this had been completed.
- There was 100% validation of professional registration for nurses working in the outpatients department. This meant that the hospital conducted annual checks to ensure that nurses were registered with the Nursing and Midwifery Council. This is considered good practice.

Good

Outpatients and diagnostic imaging

- Nursing staff said that they took part in monthly one-to-one meetings with their manager in a supervisory capacity and reported feeling supported by their managers.
- The radiology manager who was temporarily covering the service at the hospital at the time of our inspection was the only member of staff exposing patients to radiation and had the professional training and competence to do so.
- Staff underwent training suited to their individual needs. There was a plan in place for staff in the outpatients department to provide phlebotomy services for preoperative patients. A training programme was being put into place once the plan had been implemented.
- All staff in the department had attended customer care training as part of their corporate hospital induction.

Multidisciplinary working

- We observed that the team worked well together. It was a small facility and this assisted with maintaining good multidisciplinary working.
- Nursing staff reported that they would contact consultants directly to discuss patients' care, and felt that this was always responded to positively.
- Multidisciplinary working with the local NHS trust and clinical commissioning group took place regarding NHS patients.

Seven – day services

- Most services operated between 8am and 8pm Monday to Friday, with clinics occasionally scheduled for a Saturday morning.
- On discharge, patients were given the contact details for the nurse on call. This meant they were able to access support and advice remotely.

Access to information

- Outpatient staff received medical information regarding NHS patients from their GP as part of the referral process via the NHS referral service. The NHS referral service is a national electronic referral service, which gives patients a choice of place, date, and time for their first outpatient appointment, in a hospital clinic
- Outpatient staff told us that they had a good relationship with local GPs and contacted the various surgeries when necessary to query information or ask for further information regarding patients that had been referred to the service.
- All diagnostic images were orthopaedic examinations and were reviewed immediately. This meant that there was no wait for patients receiving the results of their examination.
- Test results, for example wound swabs, were faxed to the hospital and were received to a secure dedicated fax machine located in the outpatient's office. Nursing staff reviewed the results and administration staff were then responsible for putting the results in the patient's notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had an up to date consent policy and consent was obtained on the day of the surgical procedure.
- Verbal consent was obtained prior to any diagnostic imaging.
- Staff understood their responsibilities regarding mental capacity, Deprivation of Liberty Safeguards and consent. We saw evidence that training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was available to staff. However, we only saw evidence to demonstrate four registered nurses in the hospital had received this in 2016.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good for outpatients and diagnostic imaging services.

Compassionate care

- Patients we spoke with said that they felt respected during their appointments, the doors were closed and it felt private.

Good

Outpatients and diagnostic imaging

- We observed that there were curtains in consulting rooms to protect patient's privacy and dignity whilst being examined.
- One patient we spoke with said 'I was a very nervous patient and the calm atmosphere put me at ease'.
- Another patient said that 'staff are always caring, this is an excellent hospital'.
- Other patients told us that they felt staff were friendly and caring.
- We observed posters around the department informing patients of the chaperone service.
- Consultant rooms were private and could be used to speak to patients away from the waiting area if required.
- We observed staff being polite and friendly towards patients.

Understanding the involvement of patients and those close to them

- Patients received information after their pre-operative assessment appointment about what to do on the day of their surgery. For example, the name of their procedure, fasting instructions, medication instructions and the name of their nurse and consultant. This ensured that patients felt informed and involved in their care and knew exactly what to expect.
- Patients told us that they felt well informed about their procedures and that the risk and benefits of the procedure had been clearly explained in order that they were able to make an informed choice.
- Patients felt listened too by staff and felt able to ask questions about their care and treatment.
- Staff we spoke with told us that patients were able to take a relative or friend with them to their appointment if they wished to.

Emotional support

- Relatives informed us that they had been able to accompany patients to appointments and felt included in the discussions and planning. This reduced their anxiety and they were able to provide emotional support to their relative.
- We heard a receptionist communicating over the telephone with a patient who was lost and late for their appointment. The receptionist was very understanding and spoke calmly to the patient reassuring them.
- We observed that staff were sympathetic and attentive to patients' needs.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good for outpatients and diagnostic imaging services.

Where our findings on surgery also apply the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section.

Service planning and delivery to meet needs of local people

- The outpatient, physiotherapy and diagnostic imaging departments were open from 8am until 8:30pm, Monday to Friday. There were occasional clinics on a Saturday morning that allowed patients who worked in the standard opening hours to access an appointment that suited their circumstances.

Access and flow

- Most patients we spoke with told us that they received a telephone call the day before their appointment and were asked if they were fit and well and were still able to attend their appointment. This meant that patient were able to inform staff if they had to cancel their appointment instead of not attending.
- Patients would be contacted if they did not attend their appointment. If the patient no longer needed the appointment, this was recorded. If the patient still needed the appointment, a further one was made. However, if the patient did not attend for a second time they were referred back to their GP.
- Patients who required a further appointment told us that they were able to give their appointment time preferences, which they felt had been considered.

Good

Outpatients and diagnostic imaging

- Referral to treatment time is a term used to describe the period between when an appropriate referral for treatment is made and the date of the initial consultation or treatment. Between July 2015 and June 2016, 100% of patients were seen within 18 weeks of referral to the hospital.
- The hospital had no patients waiting six weeks or longer from referral for diagnostics. The diagnostic department performed plain film orthopaedic examinations only and provided an ultrasound clinic twice monthly.

Meeting people's individual needs

- The service was able to accommodate patients who used wheelchairs. There was sufficient space to manoeuvre and position a patient in a wheelchair in a safe manner.
- The service used assessable needs identification stickers to identify patients that needed assistance in accessing information. For example, patients with visual impairment or those living with a learning disability.
- Patients with a learning disability or living with dementia were offered an extended appointment time and carers were able to accompany them to clinic.
- Patients told us that they did not feel that they waited long in reception before going through to the clinic area.
- Patients told us that they received a lot of written information before their appointment and felt well informed.
- One patient we spoke with who had attended the physiotherapy department said that a 30-minute appointment was not long enough, as it had not allowed time after the therapy to ask questions.
- Translation services were available and could be accessed if needed.
- There was a drinks machine in the outpatient's reception area and a water dispenser was also available.

Learning from complaints and concerns

- Staff we spoke with told us that they tried to resolve complaints locally at the time as far as possible. They were aware of the corporate complaints policy and said that if a complaint or concern could not be resolved they would escalate to their line manager and give the patient information on how to make a formal complaint.
- We saw leaflets on how to complain in the department and in the reception area. Most patients we spoke with were aware of how to make a complaint or raise a concern. However, two out of nine patients we spoke with said that they were unsure about how to make a complaint.
- The outpatient manager received all complaints relevant to their service and gave feedback to staff about complaints in which they had been involved. Lessons from complaints were shared within the department during team meetings.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good for outpatients and diagnostic imaging services.

Where our findings on surgery also apply the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section.

Vision and strategy for this core service

- There was no specific strategy for outpatients and diagnostic imaging**.** However, there was a clinical strategy for the hospital for 2016 to 2019. The strategy provided a framework for the multidisciplinary team to ensure patients were put first, and strived for a holistic approach to patient care aiming for excellence and following the Ramsay 'people for caring for people' approach.
- Staff we spoke with were able to summarise the hospital values and discussed the 'Ramsay way', which was a corporate set of values adopted by all hospitals provided by . The values were concerned with being caring, progressive having pride and seeking new ways of doing things better.

Governance, risk management, and quality measurement for this core service

Good

Outpatients and diagnostic imaging

- The heads of department met monthly and discussed items including. Heads of departments were responsible for cascading information back to their departments and we saw evidence of team meetings where this information was discussed.
- Monthly clinical governance meetings were held. Topics discussed included, incidents, complaints and audit results. Outpatient and diagnostic imaging was also able to discuss any relevant governance issues. We saw evidence of the minutes of these meetings.
- There was a system of governance to monitor, identify and mitigate risk. There was a corporate risk register and department managers were aware of the current risks in their service.
- In diagnostic imaging, the main risk was lack of staff as the provider had been unable to recruit permanent staff for Blakelands Hospital.
- In outpatients, the main risks were the temperature control of medicines in the outpatients department and future staffing as the demands on the service were increasing. There had been steps taken to mitigate the risk of temperature control by the addition of a portable air conditioning unit. However, there was no guidance for staff available when recording temperatures, therefore abnormal temperatures were unable to be identified. We did not identify any risks within the service that were not recorded on the risk register.
- Audits were not always followed up with appropriate actions to ensure the service improved.

Leadership/ culture of service

- A registered nurse outpatient manager led the outpatient service.
- We saw commitment and support from the senior managers within the service. Staff we spoke with told us that they felt their managers were supportive and approachable and listened to their concerns.
- Staff were positive about the outpatient manager who had only been in post for three months. They told us that they felt they had a better work/ life balance since the new manager had been in post. They were proud to work within the service.
- Staff felt that they worked within a good team and that staff worked well together.

Public and staff engagement

- Outpatients and diagnostic staff told us that they felt there was a good working relationship between teams.
- The hospital distributed various newsletters to update staff on current issues and plans.

Innovation, improvement, and sustainability

- The outpatient manager reported that the department was getting busier. Referrals had risen from 340 a month to 640, over a four-month period. They felt there was a need to develop outpatient services to consider offering regular Saturday clinics.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all risks are identified on the risk register and appropriate mitigating actions taken.
- The provider must ensure that all appropriate learning is identified and shared from surgical site infection investigations.
- The provider must ensure that the World Health Organisations five steps to safer surgery checklist is completed consistently in line with the three stages.
- The hospital must ensure that audits are always followed up with appropriate actions to ensure the service improves.

Action the provider SHOULD take to improve

- The provider should ensure that all staff are aware of the strategy and vision of the hospital.
- The provider should ensure that staff are aware of the acceptable temperature limits for the safe and appropriate storage of medicines.
- The provider should ensure that all staff are up to date with training to protect children associated with the adults they were caring for, from abuse.
- The provider should ensure that the service level agreement for patient transfer includes critical care.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The regulation was not being met because: Risks were not always identified on the risk register and all mitigating actions taken. Appropriate learning was not always identified and shared from surgical site infection investigations. The World Health Organisations five steps to safer surgery checklist was not always completed consistently in line with the three stages. Audits were not always followed up with appropriate actions to ensure the service improved.