Euxton Hall 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?	Good

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We rated this hospital as "Good overall."

This was because

- There were adequate systems in place to protect people from avoidable harm and learn from incidents.
- The hospital was visibly clean and well maintained. There were systems in place to prevent the spread of infection.
- There were effective systems in place to ensure the safe storage, use and administration of medicines.
- Mandatory training levels for staff were good.
- There were adequate numbers of suitably qualified, skilled and experienced staff to meet patients' needs.There were effective arrangements in place to ensure staff had, and maintained the skills required to do their jobs.
- People received nutrition and hydration that met their preferences and needs.
- Care was delivered in line with national guidance and outcomes for patients were good.
- The individual needs of patients were met including those in vulnerable circumstances such as those living with a learning disability or dementia.
- Patients could access care when they needed it and were treated with compassion. Their privacy and dignity was maintained at all times.
- Staff were aware of the vision and strategy of the hospital.

We found areas of practice that required improvement across the hospital.

- Duty of candour processes were not always being followed as outlined in the hospital policy.
- Root cause analysis methodology was not always applied in the investigation of incidents.
- There was no process in place to risk assess or check areas of non-compliance with National Institute of Health and Care Excellence (NICE) guidance.
- The hospital risk register was not a live document and risks did not appear to be actively managed.
- Complaints were not always managed in a timely manner.

In out-patients and diagnostic imaging:

- Not all patient records included discharge summaries.
- Records did not always show if there was a safe-guarding concern for the patient.
- Records did not always show if a patient had additional needs for example, communication issues or a learning disability.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

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. There was a culture of reporting and learning from incidents amongst staff. Staff followed good practice guidance relating to the control and prevention of infection, medicines and controlled drugs were available, stored, checked and dispensed in line with good practice and legislation. Staff accessed national guidance to provide consistent good quality care. Patients were consistently happy with the care and treatment provided and we saw staff interacting with patients in a respectful friendly way, whilst being considerate of their privacy and dignity.
Outpatients and diagnostic imaging	Good 	The service was available to NHS patients and self – funding patients from the age of 18 years. The service included the main outpatient department (as well as three satellite clinics), diagnostic imaging and physiotherapy. There were processes in place to protect patients from avoidable harm and processes to monitor the effectiveness of the services. Staff were very caring to patients and supported each other. Managers were responsive to feedback to ensure a positive outcome for patients.

Summary of findings

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Summary of this inspection

Background to Euxton Hall Hospital

The hospital has had a registered manager in post for almost six years. We last inspected the hospital in October 2013 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and four CQC inspectors. There were three specialist advisors, a lead nurse with experience of working in a post anaesthetic care unit; a nurse with experience of working in an out-patient department and a specialist advisor with expertise in governance and risk management. The inspection team was overseen by Ann Ford, Head of Hospital Inspection.

Why we carried out this inspection

We inspected this service as part of our national programme of inspections of independent healthcare using our comprehensive inspection methodology.

How we carried out this inspection

This report describes our judgement of the quality of care at this location. We based it on a combination of what we found when we inspected and from all information available to us, including information given to us from people who use the service, the public and other organisations.

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.

Information about Euxton Hall Hospital

Euxton Hall Hospital is an independent hospital in Euxton, Lancashire and is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1983 and is a grade two listed building. The hospital primarily serves the communities of Preston and Chorley and South Ribble. It also accepts patient referrals from outside this area.

The hospital is registered to provide the following regulated activities:

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

Summary of this inspection

The services provided by the hospital include: audiology, cardiology, cosmetic surgery, dermatology, ear, nose and throat, (ENT), endocrinology, general surgery, gynaecology, neurology, neurosurgery, ophthalmology, orthopaedic, pain management, podiatric surgery, physiotherapy, sports medicine and urology.

Services accredited by a national body:

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

Services provided at the hospital under service level agreement:

- Decontamination for theatre.
- Histopathology.
- Microbiological support.
- Mobile magnetic resonance imaging (MRI) and computerised tomography (CT) services.
- Nerve conduction studies.
- Pathology.
- Pharmacy services.
- Provision of blood and blood components.
- Resident medical officer (RMO).
- Taxi service.

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

Are services safe?

We rated safe as good because:

- There was a positive incident reporting culture within the hospital, with the majority of incidents being no or low harm. We saw examples of learning from incidents and were able to see analysis of themes and actions taken in response to these.
- Infection control and prevention measures were in place and there had been no reported hospital acquired infections in the period July 2015 to June 2016. All areas were visibly clean and there were audits in place for hand hygiene compliance.
- Mandatory training levels were good with 100% compliance. No safeguarding concerns had been raised at the hospital in the period June 2015-July 2016. Safeguarding training was part of mandatory training and there was 100% compliance with this training and it was at the appropriate level.
- Medicines were stored and dispensed appropriately. There had been an issue with the fridge used for the storage of some medicines in the out-patients department but this had been addressed.
- There were processes in place to reduce the risks to patients including protocols for the transfer of patients in an emergency. The hospital referral criteria for surgery were for low risk patients. Surgery services were using the World Health Organisation checklist as part of the Five Steps to Safer Surgery. Resuscitation trolleys were available and checked regularly.
- Staffing including nurse staffing was good. There were vacancies at the hospital but these were covered by bank and agency staff. Theatre staffing was arranged in line with national guidance. There was a resident medical officer who was on a one week in three week rotation.
- Records were a combination of paper based and electronic records. They were stored securely while in use and when in storage at the hospital.

However;

- The treatment room, on the announced inspection, was observed as small and difficult to access in the event of an emergency situation; however, the room had been re–located at the time of the unannounced inspection.

Summary of this inspection

- There was no dedicated area to clean endoscopes for ear, nose and throat (ENT) in the OPD, except for consulting rooms, however; we saw that this was being addressed at the unannounced inspection.
- There were items identified as out of date on the announced inspection, however; this was addressed immediately and the items were removed.
- Staff told us discharge summaries were not always available in patient records at follow–up appointments.
- Records did not always show if there was a safe-guarding concern for the patient.

Are services effective?

Good

We rated effective as good because:

- Policies were based on national guidance that included the National Institute for Health and Care Excellence (NICE) and Ionising Radiation (Medical Exposure) Regulations (IR (ME) R). Staff had access to national guidance to provide consistent good quality care. Updates to guidance were disseminated to staff including consultants.
- National and local audits were undertaken to measure the quality of care and patient outcomes. Where findings could be improved, action was taken. There were examples of clinical audits undertaken as part of the Commissioning for Quality and Innovation payments framework (CQUIN's) .The hospital used the CQUIN programme to drive improvements and improve quality.
- There was effective multidisciplinary team working that included medical staff, nurses, radiographers, physiotherapists and administrative staff. Staff worked together to enhance care provision, both within the hospital and externally. Services were available across six days in theatres and seven days on the ward. Out of hours support from physiotherapy, diagnostic imaging, pharmacy and medical staffing was also available.
- Staff completed competencies and were appraised annually in line with the corporate values. All staff had completed their appraisals.
- Pain was managed and patients had access to a range of food and refreshment throughout their stay.
- There were processes in place for obtaining consent and there were three monthly consent audits. The Mental Capacity Act was included in mandatory training and staff had training and

Summary of this inspection

access to information about mental capacity, and deprivation of liberty safeguards. Patients considering cosmetic surgery underwent a 'cooling off' period to ensure they had the chance to think carefully before proceeding.

However:

- Compliance to NICE guidance was not determined by clinical audit.

Are services caring?

Good

We rated caring as good because:

- Patients we spoke with were happy with the care and treatment provided. The NHS friends and family test showed that the vast majority of patients would recommend the service.
- We saw staff interacting with patients in a respectful friendly way, whilst being considerate of their privacy and dignity. A patient-led assessment of the care environment (PLACE) audit between February 2016 and June 2016 scored 85% for privacy, dignity and well-being.
- Information was provided to patients and those close to them in a way they could understand. Visitors were welcomed to the ward to see patients.
- Counselling services were available for patients and there were specialist nurses who supported particular patient groups with one to one care and advice, these included the breast care nurses.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned to meet the needs of local people and there were three satellite clinics to make out-patient services more accessible. The environment in the hospital was pleasant and refreshments were available.
- The hospital was consistently meeting the target of treating patients within 18 weeks of their referral to the hospital and waiting times for some diagnostic screening tests were very low. There were systems in place for timely discharge of patients.
- The individual needs of patients were met. Some of the staff were dementia champions who could support patients living with dementia. Provision was made for patients with a learning disability or with complex needs. Interpreting services were available and information could be translated if necessary. Sign language services were also available.

Summary of this inspection

- There were one stop clinics for some conditions so that patients received their diagnosis and a decision about their treatment in a timely manner.

However

- The hospital had a complaints process and aimed to acknowledge and respond to complaints within 20 days, the hospital were not meeting some of the timescales for acknowledgement and response to complaints.
- There was no system to identify if a patient had a special need such as a learning disability in their patient record.

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the vision and strategy for the hospital.
- The appraisal system linked to the departmental objectives and the company values.
- The Medical Advisory Committee (MAC) minutes of meetings were comprehensive and covered the expected agenda items through the standard agenda template.
- There was a clinical governance committee at the hospital with a standard agenda template; there was also a clinical effectiveness committee that was attended by members of the medical advisory committee.
- Staff described a positive open culture at the hospital.

However

- The central hospital level risk register did not appear to be a live document and although the hospital managed risk this was not reflected by the risk register.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

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

We rated safe as good because:-

Incidents

- There was a culture of reporting and learning from incidents amongst staff and a policy to guide staff through the incident reporting process
- Between July 2015 and June 2016 staff reported 159 clinical incidents of which 138 were classified as low or no harm. There were 115 clinical incidents relating to surgery with a further 12 non-clinical incidents were reported. The number of incidents reported was lower than the average rate for independent hospitals in England.
- Staff reported incidents using a web based electronic system which produced email receipts to acknowledge submission. Staff could opt to receive written feedback if they wished.
- There were no never events reported by the hospital between July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available and should have been implemented.
- Two serious incidents were reported by the surgery service during the period July 2015 and June 2016. Both incidents related to complications following surgery.
- The clinical commissioning group had given positive feedback about the hospitals investigation reports and in both incidents and complaints we saw good evidence of seeking external expert opinions as part of the investigations.
- Following two serious incidents root cause analyses were carried out. However, we looked at the two investigation reports which did not provide adequate assurance of root cause analysis being applied. Despite this, the reports did have a comprehensive chronology and the incidents were reviewed in some detail. The matron said that they were open and honest and the hospital tried to undertake thorough investigations.
- Evidence of duty of candour being implemented was seen during the inspection for the two serious incidents but not for the moderate incidents reported. Duty of Candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. We requested further information and spoke with matron to determine whether this was duty of candour opportunities being missed or the incidents being graded incorrectly. Matron thought that it was probably a combination of both and that all the moderate incidents were likely to have a documented apology in the patient records but the full duty of candour process which included the letter following the investigation was missing. At the unannounced inspection we saw that duty of candour

letters had been sent to all appropriate patients. From this review we also saw that some incidents were minor harm as opposed to moderate harm and work was ongoing to review these incidents.

- Nursing staff and healthcare assistants we spoke with were aware of the Duty of Candour.
- We saw that changes were made following incidents to reduce the risk of recurrence. For example, staff underwent training by pharmacists following a medicine error.
- Managers told us lessons learned were fed back to staff at regular meetings and in newsletters. We saw the most recent newsletter which supported what managers said.

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

- The hospital used a clinical quality dashboard to monitor the frequency of venous thromboembolism (VTE), pressure ulcers and falls amongst ward patients. Between July and August 2016 no incidents of VTE, pressure ulcers or falls were recorded.

Cleanliness, infection control and hygiene

- We observed staff following good practice guidance relating to the control and prevention of infection. Practice was in line with the hospital's policies and procedures.
- The areas we viewed including ward and theatres (including corridors, individual patient rooms, recovery and anaesthetic rooms), corridors and storage areas were all visibly clean and tidy.
- Housekeepers used a cleaning schedule to ensure areas were cleaned and disinfected regularly. For example, rooms were cleaned following overnight stays or daily if patients remained in hospital for more than one night. We saw that staff applied 'I am clean' stickers to equipment, indicating it was clean and were ready for use.
- Laminar flow air filter systems were used in theatres and markings on the floor showed staff the outer limits of clean air areas.
- We saw posters displaying the World Health Organisation's Five Moments of Hand Hygiene giving clear instructions to staff and visitors about cleaning hands effectively.
- Rates of infection were monitored, including Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), E-Coli and Clostridium Difficile (C Diff). Between July 2015 and June 2016 there were no incidences of any of these infections at the hospital.
- Managers audited staff adherence to good hygiene practice every three months (including adherence to bare below the elbows practice, good hand washing and good drying techniques). Audits showed good compliance. For example, theatre staff audited in April 2016 demonstrated 96% compliance, rising to 97.5% in August 2016.
- Where issues were identified, action was taken to help limit recurrence. For example, since April 2016, 21 infections occurred on the ward and four surgical site infections had occurred in the period July 2015 to June 2016. Following this staff initiated further training about the non-touch technique. Figures for September 2016 showed that the rate had reduced and was no longer a concern.
- Hospital wide infection prevention and control audits were completed every three months. Between November 2015 and May 2016 overall staff compliance with good practice ranged from 80% to 90%. Actions were identified following lower scores which we saw had risen over time following staff reminders and environmental changes.
- We observed clinical staff following hand hygiene practice and adhering to 'bare below the elbows' practice when caring for patients. In theatre, we saw staff wearing appropriate 'theatre scrubs' (sanitary clothing). This reduced the risk of cross infection.

  We saw that the method for storing specimen samples was in a plastic lidded box used for storage which rested on top of other objects in a store room until removal each day by a designated driver. Managers told us this was already a concern and plans were in place to ensure sample would be stored in a more suitable sluice room.

Environment and equipment

- The majority of ward areas had newly laid laminate flooring, except for premier rooms which were carpeted. However, managers told us these were due to be re-floored as well.
- Resuscitation equipment was available in ward and theatre areas. Staff signed each day to confirm checks of the equipment had been undertaken. We saw that checks were up to date.
- Equipment in theatre areas met national recommendations (by the Anaesthetic Association of Great Britain). We checked a range of equipment used for managing a patient's airway and resuscitation. This was available, within expiry date for checks and properly maintained. All patient rooms had access to oxygen and suction equipment.
- Hepa-air filter systems in theatres were maintained with filters changed annually to ensure they remained in good working order.
- Access to the ward sluice room (an area where used disposables such as incontinence pads and bed pans are dealt with and reusable products are cleaned and disinfected) was limited with a swipe entry system to prevent unauthorised access.
- Instruments for use during operations were stored in a designated room. These were stored in trays and wrapped to maintain sterility. Expiry dates were displayed but managers confirmed there were no regular checks to make sure trays did not breach expiry. When we checked the trays, we found 15 which were out of date. Managers told us that staff checked expiration dates prior to using equipment, however we remained concerned that this single check did not adequately mitigate the risk of accidentally using out of date equipment. Managers addressed our concerns immediately by making sure all equipment trays were checked and out of date equipment removed within 24 hours of our concerns being raised. The instruments had been ordered in for surgical procedures and had not been used and should have been returned to theatre supplies at the end of the theatre session.
- Clean and used equipment were separated in theatre areas to reduce the risk of accidentally reusing equipment. Used equipment was removed daily through a designated exit. Equipment was tracked electronically which allowed staff to identify the exact equipment used for patients.
- A hoist and a hover mattress (a special mattress to ease the transfer of patients from one bed to another) were available on the ward to ensure patients could be safely lifted or transferred if required.
- Internal environmental reviews were carried and changes made where issues were identified. For example, the ward store room had stock removed and shelving installed to create space and improve access.

Medicines

- Medicines were managed according to a corporate policy which outlined requirements for staff to follow. These included ensuring medicines were stored securely at the correct temperature, checked regularly and that use was done and recorded appropriately. We saw that the date of issue and revisions were recorded on the policy which was due to review in October 2017.
- A range of medicines and controlled drugs were kept securely by theatre and ward staff in locked cupboards. Medicine usage was recorded appropriately. We checked records which showed that entries corresponded with stock levels. Records also showed that excess medicines or expired medicines were appropriately destroyed.
- Medicines used on ward rounds were stored in a trolley which was secured to the wall of a locked room. Patients own medicines or medicines for patients to take home, were also stored in locked cupboards and signed for appropriately.
- Medicine audits were completed each month. These covered security, temperature of storage areas, fridge temperatures and staff knowledge of policy and checks. Between June and July 2016, the ward scored an average of 92%, the endoscopy area scored 97% and theatres scored 93%. Comments were included with results and results were discussed in departmental meetings to help identify and act on required improvements.
- In June and July 2016 audits showed that both theatres did not record fridge temperatures on two days of both

months. Additional checks were put in place including spot checks by the matron. Subsequent checks in November, December and January showed full compliance with the monitoring of fridge temperatures.

- Medicine reconciliation was done for each in patient. There was a policy in place to help make sure that only appropriate staff (such as pharmacists) completed this task. Prescribing audits were done to check processes were being followed correctly. In November 2015 and May 2016 staff scored 100% for completing the process of medical reconciliation.
- Audits were completed to monitor the use of drug prescription charts. Between July 2015 and April 2016 ten charts were monitored with 100% compliance.
- Specific audits were completed in relation to controlled drug storage and administration. Between March and June 2016 ward and theatre areas scored (on average) 98% compliance. We checked a range of other theatre medicines which were stored in an organised way in cupboards and were within expiry date. These included intravenous fluids, antibiotics, anaesthetic agents, sodium, paracetamol and glucose. Items were clearly labelled which helped staff source the right medicine effectively.
- Medicines and controlled drugs were ordered via a local NHS trust for which the hospital had a service level agreement. Pharmacy technicians visited the hospital on a weekly basis to check, rotate and replenish stock.
- Only medical staff prescribed medicines. Medical staff were always available so there was no need for nurses to train to prescribe or for patient group directives to be used (patient group directives allow clinicians without prescribing rights to provide medicines to patients under strict criteria).
- Medicine and drug wastage were monitored monthly via an electronic tracking system. This allowed staff to identify areas of waste and implement change if necessary.

Records

- Patient records were stored securely on the ward in covered cabinets, either in a room with secure entry or behind the nurses' station where staff were present.
- Staff audited ten records each month to make sure staff completed them correctly. The audit checked that details were included such as demographics, referral letters, dates, times and staff details and legibility. Clinical details were also reviewed to check whether consultants included diagnoses, operative notes, staff details, findings, complications, details of equipment used and that a follow up phone call was made within 48 hours of discharge. Results for November 2016 showed an overall score of 95%. Trends and actions for improvement were also included and findings were referred to the medical advisory committee and ward and theatre meetings for discussion so that information could be shared with staff. We saw minutes of the medical advisory committee meetings which supported this.
- We reviewed 10 sets of patient records. Seven of these contained the correct details, with information filed in an organised legible way. Three records did not contain pre-operative assessment information, two of which were for endoscopy patients. This meant there was no evidence that patients had been properly assessed prior to undergoing procedures.
- We reviewed two records of patients who had undergone surgical operations. Here we saw that pre-operative notes, a patient pathway and risk assessments for issues such as venous thrombosis embolism (VTE) were all completed.
- Pre-operative care was audited every six months. We reviewed audits for July 2015 and January 2016 which showed pre-operative assessments were carried out in accordance with national guidance in all of the twenty records reviewed. The audit also showed that pre-operative questionnaires were completed two weeks prior to admission in 19 out of 20 records reviewed.

Safeguarding

- Safeguarding policies and procedures were in place, and staff knew how to refer a safeguarding concern in and out of hours to help protect adults and children and young people from abuse. We saw that the policy was revised when new legislation was introduced. The hospital had an appointed lead for safeguarding who

provided safeguarding training for all staff. They also had links with local safeguarding children's group and clinical commissioning groups in relation to safeguarding matters.

- Staff received web-based training depending upon the level of contact they had with patients. Female genital mutilation was covered during training (there is now a mandatory reporting duty for FGM by regulated health and social care professionals in England and Wales.)
- We noted staff used local levels of training which did not necessarily correspond with national guidance. For example, staff assured us they received level one internal safeguarding training but not necessarily level two. Whilst local guidelines stated only level one was required, national guidance requires training to level two as a minimum. However, we later identified that other internal mandatory training corresponding with level two was provided to all staff.
- Training figures showed that at the time of our inspection, 93% of ward staff and 94% of theatre staff were up to date with appropriate safeguarding training for adults and for children where required.
- Staff used a flow chart to help them process safeguarding concerns, including out of hours concerns. This was displayed on a noticeboard for staff to view. Information was also stored in a 'grab file' forward staff to access if needed. Safeguarding was a standing agenda item on staff meetings to ensure information was shared regularly. A flow chart to help staff identify and report FGM was also in place.

Mandatory training

- All staff were required to undertake mandatory training, which was provided by e-learning or classroom based. Topics included basic life support, infection control, manual handling and information governance.
- Managers stored details about staff compliance with mandatory training. On the ward, 100% of staff were up to date with mandatory training. Seven staff were due to complete training in December 2016. In theatres 22 out of 25 staff were up to date with training.
- The ward manager arranged training for ward staff at the beginning of each calendar year to ensure dates were booked in good time.

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

- Risks in ward and theatre areas were identified, managed and mitigated where possible to help keep patients safe.
- The hospital set out pre-defined referral criteria to ensure only low risk patients were accepted for surgery or that known risk factors such as hypertension (raised blood pressure) or diabetes were referred to consultants prior to acceptance for surgery. This reduced the risk of patients experiencing complications during or immediately after surgical procedures.
- Patients had access to medical input at all times, if required. During the day, consultants or the resident medical officer (RMO) were available to provide urgent assessment or care if required. The RMO was also available out of hours. Resident medical officers were sourced from a recognised company which helped to ensure they were suitably qualified for the role. Managers told us that other on call medical staff such as anaesthetists were available if required with a maximum 30 minute travel time.
- Staff received higher training in life support techniques should a patient deteriorate and require resuscitation.
- All theatre staff were trained in intermediate life support (ILS) and hospital staff planned staffing to help make sure at least one staff member (such as the RMO, anaesthetist or specially trained nurses) with advanced life support skills was on duty at all times.
- On the ward, both the ward manager and nursing sister were trained in ALS however; certification for one of them had expired. All other nursing staff were trained in ILS with another due to complete refresher training in November 2017.
- Clinical staff used early warning scores to help identify patients whose clinical observations indicated their condition was worsening. Use of early warning scores were audited twice yearly and results in September 2015 and March 2016 showed staff recorded scores in 100% of cases reviewed (ten per audit)
- The hospital was using the sepsis six pathway and the sepsis screening tool which was part of the pathway. Staff had received training in using the pathway.

- Information about patient allergies was sourced and noted in records during pre-operative assessment. This limited the risk that patients with severe allergies may be exposed to allergens during their stay. Additionally, the ward corridor was kept free of latex and managers told us patients with latex allergies were placed first on theatre lists to reduce the risk of exposure through the day. Audits done between July 2015 and April 2016 showed that allergies were recorded in all but one record reviewed, giving an overall compliance score of 98%.
- In theatre, nurses followed the World Health Organisation (WHO) Surgical Safety Checklist prior to, during and post-operatively as part of the Five Steps to Safer Surgery. The WHO (World Health Organisation) checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre. This helped to make sure surgery was conducted safely through standard internationally recognised checks.
- We observed two surgical procedures and saw that the WHO checklist was completed. Audits done in December 2015 and June 2016 showed that staff consistently scored 100% for following the principles of the WHO surgical safety checklist. These audits were carried out by the WHO checklist champion.
- Theatre staff kept formal records of important details, such as patient identity, staff present and anaesthetic and swab types used. This helped ensure that details could be retrieved retrospectively should they be required.
- Blood for transfusions was securely stored to ensure treatment could be arranged quickly should it be required. The hospital had a major haemorrhage procedure, available for staff to access quickly if required.
- There was a team in the hospital that included the RMO and registered nursing staff who could deal with patients whose condition deteriorated.
- We saw laminated documents on tables in patient rooms explaining how to reduce the risk of falling whilst in hospital.
- Systems were in place to help staff organise rapid transfers to emergency care facilities should it be required. This included an algorithm, sealed emergency transfer drug packs and equipment bags to help manage a patient's airway, breathing and circulation whilst on route.
- In ward areas patients had access to call bells, allowing them to summon help quickly if required. All the patients we spoke with on the ward, had call bells placed on their bed or into their hands depending on preference.

Nursing and support staffing

- Staffing was arranged in an organised way in both theatre and ward areas, depending upon patients' needs. Rotas were approved by theatre managers and matrons prior to publication.
- On the ward, 18 whole time equivalent nurses, three healthcare assistants and four regular bank nurses were employed. Two regular agency staff supported numbers if necessary. In theatres and endoscopy areas nine nurses and four operating department practitioners (ODPs) were employed, with five regular bank staff and agency staff used depending upon requirements.
- Two staff employed by the hospital and one bank staff member were trained as surgical first assistants. (SFAs) are registered healthcare professionals who provide continuous competent and dedicated assistance under the direct supervision of the operating surgeon throughout procedures, whilst not performing any form of surgical intervention.
- Theatre staffing was arranged in accordance with national guidance (Association for Peri-operative Practitioners). 75% of staff were substantive with the remaining 25% being regular agency or bank staff. This gave managers flexibility depending upon requirements.
- On the ward there was one nursing and one healthcare assistant vacancy at the time of our inspection. In theatres there were two nurse vacancies and one ODP vacancy. Recruitment was in progress including a recruitment day in October 2016, and rolling adverts on NHS and corporate websites. One part time nurse had

been recruited but had not yet started work. Despite vacancies, the ward manager told us she felt assured that staffing was safe, using agency and bank staff to support staffing where necessary.

- Nurses underwent revalidation relating to their professional registration. Four nurses had been through the process and managers told us this had been successful.
- Staffing on the ward was organised two weeks ahead based on planned theatre lists. However generally staffing was planned to ensure there were five nurses on early shifts, five on late shifts and two nurses overnight. This equated to an approximate ratio of one nurse to every four patients during the day and two nurses to every nine patients at night. One healthcare assistant worked on each of these shifts as well. We reviewed the ward rota for a random week in September 2016 and saw that staffing was in line with this.
- Managers did not use acuity tools to measure staffing requirements. However, they confirmed that planned staffing levels were equivalent to national guidelines such as the National Institute of Health and Care Excellence (NICE) and guidance by the Shelford Group (2014) (a group comprising ten leading NHS multi-specialty academic healthcare organisations)
- Succession planning took place to ensure other staff were in a position to take over senior positions following retirement. For example, on the ward, two other nurses were familiar with organising nurse staffing and in the endoscopy unit a senior nurse was due to take a senior position following a number of months of preparation prior to formally applying for the role.
- Staff sickness was managed. Figures showed sickness levels for theatre nurses fluctuated between 0% and 20% between July 2015 and June 2016. For ward nurses the figures also fluctuated between 0% and 30%. Managers told us that four ward staff and four theatre staff had been absent from work over the last year with long term sickness. Additionally, having low numbers of staff, had affected sickness figures making them appear higher than average. For example, a 30% sickness rate in healthcare assistants equated to a single staff member being absent. Despite this, we also saw that between April and June 2016 there were no unfulfilled shifts as a result of sickness.
- Following periods of sickness, staff attended 'return to work' interviews to assess whether any extra support was required or identify causes of sickness. Following review, managers told us that no trends had been identified regarding long term sickness in teams and that absence had been unavoidable based on individual circumstances.

  Handovers were provided on the ward each day at approximately midday and prior to surgery lists in theatre. This gave staff an opportunity to share details about patients such as allergies, and operational issues such as operations overrunning were discussed. However, there were no minutes or other documentation to corroborate this. Recording details of daily meetings can provide useful contemporaneous information should investigations be undertaken.

Medical staffing

- Consultants were not directly employed by the hospital but instead practised under practising privileges (permission to practise as a medical practitioner in a particular hospital).
- There were 67 surgeons, 24 anaesthetists and one physician who worked at the hospital under practising privileges.
- A resident medical officer (RMO) was on site 24 hours a day, seven days a week, should staff require immediate medical assistance either within or out of hours. Managers described RMOs as very good, having been sourced from a recognised company.
- Other emergency surgical cover was also provided and met the requirement for a response within 30 minutes.

Emergency awareness and training

- A policy was in place to help make sure business continuity was not affected by adverse incidents such as fire or electrical failure. Uninterrupted power supply (UPS) generators were used to make sure power was not interrupted.
- There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of procedures in the event of fire. Weekly fire alarms testing took place. Equipment to help evacuate patients from theatre and ward areas was also available.

Good

Surgery

- Scenario based training took place to ensure staff could respond appropriately should there be a fire. The latest scenario had been completed three months prior to our visit and involved an unannounced fire alarm with simulated smoke created in a staff area. This exercise helped to familiarise staff and to provide reassurance of their abilities to follow fire procedures.
- An emergency file available on the ward stored emergency contact details and plans for dealing with emergencies such as bomb scares.

Are surgery services effective?

Good

We rated effective as good because

Evidence-based care and treatment

- Staff used national guidance to provide consistent good quality care to patients. For example, guidance by the National Institute of Health and Care Excellence (NICE) for pre-operative assessment. We saw evidence that updates to guidelines and local policies were emailed to managers and disseminated to staff in staff meetings.
- There were examples of clinical audits undertaken as part of the Commissioning for Quality and Innovation payments framework (CQUIN's) .The hospital used the CQUIN programme to drive improvements and improve quality. One of the CQUINS was about the implementation of National Institute for Health and Care Excellence (NICE) guidance. Audit results were reviewed at the medical advisory committee meeting
- We saw evidence of the dissemination of new NICE guidance in the minutes of meetings and there was a process for determining whether the guidance was applicable to the services. However compliance to NICE guidance was not determined by clinical audit.
- Guidelines, policies, and standard operating procedures were accessible via the hospital intranet system. We saw staff access guidelines with ease during our inspection. We reviewed a random selection of policies and saw that publish and review dates were included. Those we checked were within the documented review date.
- Audits were managed centrally by the hospital and facilitated by departmental staff to help identify areas of good practice or areas for improvement.
- In September 2016 oxygen prescribing for patients was audited. Seven patient records were reviewed showing only four contained completed prescriptions. Action was taken to improve this by introducing a checklist prompting staff to complete prescriptions. A further audit was planned in March 2017 to measure improvement.
- Audits to measure how well staff sourced and evidenced consent from patients took place every three months. For theatre staff, results for September 2016 showed 92% compliance. A further audit was planned for December 2016.
- Surgical safety was audited every three months. The audit included use of debriefs, inclusion of documents in patient records, the use of the World Health Organisation's Surgical Safety Checklist and record keeping. The audit in August 2015 produced an overall score of 63% with concerns identified in the endoscopy department. Following actions to address these, the audit was repeated in September 2015 producing a score of 95%. We saw that this standard was maintained across theatre and endoscopy areas with scores of 93% in February and 95% in May 2016.

Pain relief

- Staff checked and recorded the level of pain patients experienced using a scale between zero (no pain) and ten (extreme pain). Audits completed in July 2015 and January 2016 showed that pain was consistently managed and recorded in patient records, with overall compliance scores of 100%. Further audits in June and July 2016 also showed consistently high scores (95% compliance for both months).
- Endoscopy patients were asked to rate their experience relating to pain, better, same or worse than expected. There was a question on the 48 hour follow up call that asked about pain control and if it was within an acceptable level to the patient and all patients are asked to take part in an online survey which also gave them the opportunity to comment about their pain control.

- A range of medicines were used to help patients manage pain. These were stored appropriately and were accessible to designated staff in required areas of the hospital.
- Patients we spoke with said pain was managed effectively and that staff regularly asked them if they were comfortable. Where patients experienced pain, they told us this was dealt with efficiently.

Nutrition and hydration

- Patients were cared for prior to surgery by identifying nil by mouth requirements on room doors. This reminded staff not to provide food and drink to patients waiting to go to theatre.
- No food was provided for patients in theatre areas other than small amounts of water if appropriate in recovery bays. This was because patients stayed in the recovery area for only a short length of time before being returned to the ward for assessment and food provision if appropriate.
- Dietary requirements were assessed during pre-operative assessments with any dietary requirements sent to the chef.
- The catering staff informed the ward staff if any patient was not eating their meals and either the chef or the nursing staff would go to see the patients to discuss their needs. Nutrition and hydration was also mentioned on the follow up call to patients 48 hours after discharge from the hospital. One of the questions that was asked was if diet and fluids were being tolerated and if a patient said no a qualified nurse made a further call to assess the patient. Food was also mentioned in the follow up survey.
- The ward provided patients and visitors with hot and cold food and refreshments during their stay. Patients had a range of meals to choose from including soup, sandwiches, hot breakfasts, lunches and dinners.
- Audits to review food and nutrition for patients were done every three months. In December 2015 compliance was 80%. Out of ten patient records reviewed, three did not include evidence that dietary advice was given to patients with a body mass index of over 30 or fluid being given to patients delayed going into theatre. Actions were identified to improve scores such as reminding staff and allocating named nurses to take responsibility for food and nutrition. A further audit completed in June 2016 showed some improvement with an overall compliance score of 86%.
- Ward managers told us that more recent audits completed in February had identified similar issues with fluids for patients delayed going to theatre. Despite introducing a fluid balance link nurse (a nurse with a special interest in fluid balance) results had not shown significant improvement. Further review identified improvements could be made to the fluid balance chart itself which was in progress at the time of inspection.

Patient outcomes

- The hospital engaged with the Private Healthcare Information Network (PHIN). This network collates and publishes information about private healthcare under the Competition and Markets Authority Private Healthcare Market Investigation Order (2014). By engaging with PHIN, the hospital were acting in accordance with legal requirements.
- Staff collated data for national audits. The data formed patient outcome performance measures (PROMs) following orthopaedic surgery, where patients completed questionnaires to review improvements following surgery. Published results for the period April 2014 to March 2015 showed that improvements were within the estimated range. For example from knee replacements 77% of patients reported improvements to general health and 91% reported improvements in relation to function and pain. Following hip replacement 88% reported improvement and 96% reported specific improvements relating to function and pain. These were comparable to the England average. Lower scores were given in relation to groin hernia repair and 49% of patients reported improvement to general health following surgery. These outcomes were comparable to the England average.
- Unplanned readmissions were also monitored and investigated through the incident reporting process. These can indicate poor care when patients have to return for further care unexpectedly. Between July 2015 and June 2016 the hospital reported eight unplanned

returns to theatres and 17 unplanned readmissions to the ward within 28 days of discharge. This was in line with the average rate for independent hospitals in England.

- The hospital was involved in the Commissioning for Quality and Innovation (CQUINs) payments framework 2016/17 for hip and knee surgery. The framework encourages care providers to share and improve how care is delivered to achieve transparency and overall improvement in healthcare. Funding is provided based on results. Staff would focus on providing timely care such as taking a temperature and prophylactic antibiotics within one hour of surgical incision, administering tranexamic acid during surgery and the patient being able to walk within 24 hours of surgery. This was in progress at the time of inspection and due to continue until March 2017.

Competent staff

- All staff completed inductions and competency checks to ensure they were aware of corporate and (where necessary) up to date clinical practice.
- We checked a numberof staff files and saw that staffinductions had been completedThe induction checklist included flow of patients, location of resuscitation, oxygen, suction and emergency equipment, fire procedures, record keeping policy, safety and security, medicines policy and training.
- We checked five consultant files including two where the consultant was not employed in the NHS. We saw that all the consultants had completed their appraisals and all of them were in date. We also saw evidence of indemnity insurance and evidence of the training records of the consultants. All were up to date.
- Competency assessments were completed for clinical staff working in theatre; these covered a range of topics that helped to maintain clinical standards. Competency assessments included sharps (needle) safety, intravenous drug administration, post-operative pain relief and managing deteriorating patients.
- Link nurses (nurses with a special interest in certain subjects who pass on knowledge to other staff) were in place in areas including health and safety, pain management, tissue viability, transfusion, endoscopy, manual handling, fire safety and medicine management. Link nurses contributed to meetings regularly to share knowledge
- Consultants were not directly employed by the hospital but instead practised under practising privileges (permission to practise as a medical practitioner in a particular hospital). Managers told us that staff worked on the assumption that consultants had been granted privileges appropriately through the corporate process. However, where queries arose managers checked to ensure care was provided appropriately under these privileges. For example, following a surgeon's request to list a patient for surgery which had never been undertaken at the hospital, privileges were checked before confirming with the doctor that surgery could not be scheduled. This was because other staff were not familiar with the procedure which could pose a risk to the patient. Instead the surgeon was offered a different hospital under the Ramsey Healthcare company where surgery could be performed without increased risk.
- Appraisals were completed every year and there was a mid- year review for staff. All staff were up to date with appraisals. Staff working in surgery were offered clinical supervision.

Multidisciplinary working

- Staff from a range of disciplines worked together internally to provide holistic care for patients. For example, physiotherapists, radiologists, radiographers, nurses, healthcare assistants, administrators and doctors all worked together each day.
- Links with other NHS trusts that provided pharmacy services were in place with service level agreements to make sure arrangements were understood between the two organisations. Other links with NHS trusts were also in place for support with emergencies such as major haemorrhage or difficulties intubating patients following anaesthetic.
- Ward staff formed part of the South Lancashire and Cumbria Critical Care Network and attended meetings approximately three times a year.
- A GP liaison officer worked to form links with local GP networks to improve knowledge of what the hospital could provide for local patients.

Good

Surgery

Seven-day services

- Theatres operated between the hours of 8am and 8pm on weekdays and from 8am until 6pm on Saturdays. The ward was open seven days a week.
- The ward reception area was open from 7am until clinics finished during the week and between 7am and 3pm at weekends.
- On the ward, staff could access services such as X-Ray, physiotherapy and pharmacy out of hours if required.

Access to information

- Staff had access to a corporate intranet service which gave access to policies, procedures and guidance. We saw staff navigate this with ease. The guidelines and policies we reviewed including those relating to consent, safeguarding and medicine management were all within the required review date.
- Consultants we spoke with told us they were able to access all the information they required to care for patients effectively.
- Clinical staff had access to the regional picture archiving communication system. This system allowed staff to review images (such as x-rays) taken throughout the region.
- The hospital aimed to complete discharge letters, providing one copy for the patient and the original for the GP within 24 hours of discharge. Audits completed in July 2015 and January 2016 showed that staff complied with this requirement in all of the 20 cases reviewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw information for staff about the Mental Capacity Act and Deprivation of Liberty Safeguards, which was stored in a main office and readily available for staff. Other information relating to deprivation of liberty safeguards, capacity assessment and the role of independent mental capacity advocates (statutory advocacy introduced by the Mental Capacity Act 2005 (the Act) which gives some people who lack capacity a right to receive support from an Independent Mental Capacity Advocate) were also included.
- Managers told us that because patients were selected prior to admission based on criteria mental capacity issues were extremely rare. For this reason, the ward manager said that no requirements for deprivation of liberty safeguard applications had ever arisen.
- The hospital had a policy in place to help staff manage the consent process for patients. We saw that the policy had been recently reviewed and was due to be reviewed again in 2019. The policy referred to the principles of consent as well as a patient's mental capacity to consent under the Mental Capacity Act (2005).
- Consent was provided using a two stage process, obtaining consent prior to the day of surgery and again immediately prior to surgery.
- The policy also outlined a cooling off period for patients wishing to undergo cosmetic surgery. Having a cooling off period allows patients the time to fully consider the implications of surgery prior to proceeding.
- The consent process was audited every three months. Results between November 2015 and June 2016 produced an overall compliance score of 92%. We saw that areas of lower compliance were reviewed to identify trends and action to improve results. Actions included referring to the medical advisory committee for discussion and sharing findings with staff to encourage improvement in areas such as giving patients a contact number should they wish to discuss consent at any time. We saw evidence that actions were implemented to help improve results.

Are surgery services caring?

Good

We rated caring as good because:-

Compassionate care

- Feedback from people using the service was continually positive about the way staff treated them. They told us staff were 'brilliant' and 'really wonderful' and that they were very happy with the care provided to them.

Good

Surgery

- We saw staff interacting with patients with a positive, friendly manner. They showed patients around prior to settling them in their rooms. In recovery areas, staff made general conversation with patients in between asking them how they were feeling.
- We saw staff closing doors to patient rooms, and knocking before entering to ensure dignity and privacy were maintained. Patients we spoke to felt their dignity and privacy was respected by staff particularly when helping them to wash and shower. Survey results supported what we told and what we saw. They were consistently good in relation to Friends and Family questionnaires. These questionnaires helped capture important information about patient care by asking patients how likely they would be to recommend services to friends or family members. We reviewed findings from August and October 2016 which showed that 100% of day case patients would recommend services. For patients who stayed in the hospital overnight, 100% of patients surveyed in August 2016 said they would recommend services with 96% in October 2016. The response rates were between 50% and 65% which meant findings were robust and reliable.

Understanding and involvement of patients and those close to them

- At the start of each day nurses were assigned to particular areas of the ward so that patients were cared for by individual staff. Patients told us that staff introduced themselves which made them feel more comfortable.
- All the patients we spoke with told us that staff had explained everything to them very well and in a way that was easy for them to understand and that staff had time for them 'every step of the way'.
- There was open visiting for carers and they were allowed to stay overnight in a reclining chair with patients if they wanted to.
- Patients also told us loved ones were made to feel welcome by staff.

Emotional support

- Counselling services were available for patients who required bariatric (weight loss) surgery to help them cope with the social and psychological aspects of weight loss surgery.
- Clinical nurse specialists for breast care were available to offer support for patients. The ward manager told us that nurses were developing links with specialist urology nurses in a local NHS trust to expand the provision of care in this area.

Are surgery services responsive?

Good

We rated responsive as good because

Service planning and delivery to meet the needs of local people

- Services were planned and delivered in a way that met the needs of the local population.
- The hospital formed part of a local systems resilience group. This group acted as a forum where partners across the local health and social care system met to undertake regular planning of service delivery to ensure services were resilient.
- Following feedback from patients, plans were changed to help meet their needs.For example, admission times were staggered to avoid unnecessary delays.
- Facilities and premises were appropriate for the services which were planned and delivered. Theatre areas were bright with adequate space to provide care. There were two theatres, with separate rooms for administering anaesthetic and for recovery following surgery.
- The ward area was pleasant; with wide corridors, soft lighting and accessibility to each room should staff need to attend to patients.
- Equality impact assessments were undertaken to ensure facilities gave access to those with impaired mobility. Policies were also reviewed to make sure they benefited patients without exception.
- Care and treatment was coordinated with other services and providers. This meant that access to care was managed using protocols such as rapid transfer for those requiring emergency care.
- The hospital was involved in the Commissioning for Quality and Innovation (CQUINs) payments framework. This framework encourages care providers to share and

continually improve how care is delivered by offering monetary incentives for the provision of good care. CQUINs were in place for patients with venous thromboembolism, dementia and sepsis. As a result of CQUINs staff had developed a dementia screening tool and made changes to visiting hours and signage to assist patients.

Access and flow

- Between July 2015 and June 2016 there were 6,192 inpatient and day case episodes of care. Of these 90% were funded by the NHS who commissioned the hospital to provide care for patients. The remaining 10% of patients were funded by other means, for example, through private healthcare arrangements.
- The hospital worked to ensure at least 95% of patients were admitted within 18 weeks of referral in line with the national target set by the Department of Health. Between July 2015 and June 2016, 100% of patients were referred within 18 weeks except for May (99%) and June (92%).
- Staff from a range of professions including managers, admissions staff, physiotherapists and radiographers attended weekly 'activity' meetings to discuss planned admissions two weeks in advance. Additionally, each day the ward manager liaised with admissions staff to check for any additional patients requiring admission. This helped staff ensure the right numbers of staff from each discipline were available to care for patients.
- Operations were planned in an organised way with two or three sessions (lists of patients being treated by one surgeon) scheduled daily.
- The ward manager told us that discharge planning for patients began upon their arrival with a clear plan for ensuring they were discharged effectively with appropriate support when fit to leave.
- Managers told us patients were not discharged after 10pm (and only then if they were young and mobile) which helped reduce the risks for more vulnerable patients returning home late at night.
- Some staff told us that theatre lists often over-ran causing them to work longer than anticipated hours. They told us that some theatre lists, planned in advance were 'unachievable' in the expected time frame. This was particularly apparent when three lists were planned in one day. We discussed this with managers and reviewed shifts for three randomly selected staff over a three week period. Here we saw that despite staff finishing later than anticipated on four days out of twelve reviewed, they finished earlier than planned on the other eight days. On two of these days staff finished over one hour earlier than planned and on a further two days, over two hours earlier. Managers also showed us how start and finish times were recorded and how the balance in hours was negotiated on an informal basis. For example, staff chose whether to work extra hours on other days, or have time off in lieu.
- Cancellations were monitored through the scheduling system. Between July 2016 and June 2017 the hospital reported four procedures cancelled for non-clinical reasons. All these patients were offered another date within 28 days of the cancelled appointment.
- We reviewed cancellations on the system the week of our inspection which showed a further three procedures were cancelled. Two patients had cancelled the procedure themselves and another was unable to proceed due to being unwell. We saw that changes were made to help reduce cancellations. For example, schedules for theatre were adjusted to ensure one surgeon was not affected by time constraints.
- Unplanned transfers to other hospitals, unplanned admissions within 28 days and returns to theatre were also monitored. Out of 267 patients admitted between January and March 2016, two were transferred, and out of 271 admissions between April and June 2016, four patients were transferred to other hospitals. In relation to unplanned admissions, 17 patients returned between July 2015 and June 2016. These results were not high in comparison with other hospitals that provided data. Similarly, only eight patients were returned to theatre unexpectedly between July 2015 and June 2016.

Meeting people's individual needs

- In-patient rooms had en-suite facilities, television and windows which made them feel light and spacious.
- Patients in ambulatory rooms had access to a water cooler, television and magazines and a toilet. Each room was assigned to either male or female patients to preserve dignity.

Good

Surgery

- The hospital along with the other Ramsay hospitals in the North West had developed a dementia policy and communication strategy as part of the undertaken as part of the Commissioning for Quality and Innovation payments framework (CQUIN's). This had involved dementia training for champions, dementia friends and e learning for some staff, changes to the environment and a patient survey for carers and patients with dementia. Dementia training was included in mandatory training for appropriate staff.
- Leaflets were available for patients to take away with them. These provided information about what to expect after procedures. They were available in a range of languages for patients whose first language was not English.
- Religious needs were catered for by staff. On the ward, staff had access to a folder with information about a range of religions and associated customs. Managers explained that they could contact the local priest for patients of Christian faith who wanted to pray. Individual rooms acted as prayer rooms for patients. Staff placed "do not disturb" signs on doors if patients were praying.
- Discharge packs were made for people to take home with them. These included relevant information leaflets for patients to read which were printed as required to ensure information was up to date. Leaflets were available in large print or in a range of languages to ensure all patients had access to information.
- For patients whose first language was not English, interpretation was arranged via a recognised language interpretation company.
- There was provision for patients who were undergoing weight loss surgery. Bariatric tables (used in theatre) and shower chairs were available as well as a specific pathways including advice about food, eating habits and activity post-surgery as well as providing useful contact numbers.
- A patient-led assessment of the care environment (PLACE) audit between February 2016 and June 2016 scored 69% for dementia which was lower than the England average of 80%.
- Managers told us that patients with learning disabilities or complex needs were individually assessed upon arrival to ensure care could be tailored to suit their needs. Examples of tailored care included reducing waiting times by placing them first on theatre lists or allowing relatives into the treatment areas.

Learning from complaints and concerns

- The complaints process aimed to acknowledge complaints within three days and to provide a full response in 20 days. Of the five complaints that were reviewed, the relevant timescales had not been met in all of the cases. This was due to the complexity of the cases and the processes at the hospital.
- One of the complaints that we reviewed had numerous delays in the process. The hospital had missed every deadline to the patient throughout the complaint. The latest date that the complainant had been given for a full response was for the week following the inspection (this was four months following his initial complaint). We saw at the unannounced inspection that this deadline had been met and a full response had been sent to the patient. The managers at the hospital acknowledged that the complaints procedure was an area for improvement.
- Complaints were agenda items at the medical advisory committee meetings and at the senior management team meetings to discuss themes and actions arising from the complaints.
- There was a complaints policy in place to help staff manage the complaints process.
- Between February and July 2016 surgery services received three complaints. These related to cost quotations, and surgical outcomes.
- Managers told us that staff would try to diffuse issues raised at the time through communication. Should someone wish to make a written complaint, leaflets were available explaining the complaints process.
- We saw examples of 'hot alerts' which were communications sent by email to staff, advising them of negative feedback. Complaints were discussed at governance meetings.

- Managers investigated complaints and formulated responses which were collated by the hospital management team. Additionally, they told us they would offer to meet with complainants in an effort to resolve concerns.

Are surgery services well-led?

Good

We rated well-led as good because:-

Vision and strategy for this this core service

- We were told about the "Ramsay way" and how the values were lived and breathed by the staff. We spoke with staff that were able to give examples of how these values contributed to their roles.
- There was a regional strategy, the "Northern Blitz Spirit" and each department set objectives that contributed to this strategy. A review of the strategy was due in January 2017 to evaluate progress. We saw how the appraisal process linked to the departmental objectives and the company values. There was a clinical strategy that linked into the Northern Blitz Spirit which was based on the five domains of the Care Quality Commission.
- Senior staff we spoke with were aware of the regional strategy which they explained, centred on making people (patients and staff) a priority. A strategy meeting held in May 2016 involved discussions about how each department could feed ideas in and meet the vision and values requirements. Findings were then disseminated to staff in departmental staff meetings. Actions were devised such as empowering staff to provide better care through encouragement to challenge poor care. The action plan was reviewed in August and November 2016. The manager told us that actions had led to fewer occasions where challenges were deemed necessary and an overall improvement in care.
- The hospital strategy was discussed at clinical governance and senior management team meetings that were held each month. Staff discussed their understanding of the hospital values and the strategic plan as part of the appraisal process.

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

- There were monthly departmental meetings and information from these meetings were used to inform the heads of department meetings which were also held monthly. The senior management team at the hospital had monthly meetings and information from these meetings was cascaded down to the heads of department meetings and then to departmental meetings so there was a flow of information between the senior management team and staff.
- There was a committee structure at the hospital which included health and safety, clinical effectiveness, the medical advisory committee and the clinical governance committee. There were regional meetings and national meetings that were attended by members of the senior management team.
- The hospital risk register did not appear to be a live document. We reviewed 39 risks from the risk register, of these risks 21 had been added in January 2014 and no further risks were added until August 2016. Risks did not appear to be actively managed and were not closed when the acceptable risk level was reached.
- The hospital risk register did not capture clinical risk, but despite the risk register not working as a tool to manage risk we felt assured when we spoke with them that the hospital management team were aware of the key risks and had plans in place to manage them.
- A departmental risk register was in place and each department completed risk assessments to make sure risk was documented and managed effectively. The risks we saw on the risk register corresponded with managers' concerns. Details such as a description of the risk, current status, risk score, date opened, review date, person responsible for managing the risk, and assessment of the impact of the risk, potential causes and controls and an action plan to mitigate the risk were included.Any risk scoring eight or above were reviewed at health and safety meetings.
- The Medical Advisory Committee (MAC) minutes of meetings were comprehensive and covered the expected agenda items through the standard agenda template. Meetings were every three months. We saw that incidents and complaints, continuing professional

development, infection control and National Institute for Health and Care Excellence (NICE) guidance were discussed. The minutes of the clinical effectiveness meetings and the clinical governance meetings were standing agenda items.

- Practice privileges were managed outside of the MAC if necessary to ensure timely management but were always recorded in the minutes. There were no timescales for actions and some actions had been on the agenda for a prolonged period of time. We spoke with the MAC chair and discussed an example that had been on the agenda for almost two years. The MAC chair provided an explanation of why this action had not been completed. They agreed that timescales would be useful to set out the actions and the risk of these actions not being completed.
- There was a clinical governance committee which met every three months and had a standard agenda which covered appropriate topics. The minutes were detailed and captured the information shared at the meeting, there were actions and timescales for their completion and actions were summarised at the end of the minutes. Attendance at the meeting did not include representation from the MAC though the clinical governance minutes were an agenda item for the MAC.
- There were monthly clinical governance meetings as well as departmental meetings every six to eight weeks. Meetings followed a set agenda to ensure important items such as audit, agency use, link nurse knowledge, policy or legislation updates and safeguarding were discussed.
- There was no representation from the medical advisory committee on the clinical governance committee but there was medical representation on the clinical effectiveness committee which were held every three months. Agenda items on the clinical effectiveness committee included clinical indicators, audit reviews, patient satisfaction surveys, NICE guidance, incidents and lessons learned and a risk register update. The minutes of these meetings were an agenda item on the medical advisory committee meetings along with the minutes of the clinical governance committee meetings.
- The Ramsay hospitals in the North West England worked together on a number of projects including CQUIN's. All the Ramsay hospitals benchmarked themselves against each other. The outcomes of the benchmarking were discussed at the MAC meetings.
- There was a comprehensive programme of audits at the hospital.
- Departmental managers explained that although medical advisory committee meetings were held on a regular basis, they did not routinely attend these. They told us they would attend if an agenda item required them to do so.

Leadership / culture of service related to this core service

- All the staff we spoke with spoke highly of line managers and the senior hospital managers. They described them as supportive whilst allowing them to act with autonomy.
- The culture was described as supportive, positive and friendly. Staff said they worked well with colleagues. A number of staff we spoke to had worked at the hospital for more than five years and said they were very happy to work there.
- Support was made available for staff. For example, managers arranged counselling for staff if they needed additional or ongoing support.
- Senior leaders were visible to staff, visiting weekly or monthly. Staff said they responded to emails sent directly to them which helped staff to feel communication was effective.
- The hospital was completing the workforce race equality template which had a supporting action plan and report.

Public and staff engagement

- There was a staff survey "My Voice" in 2016 that had highlighted a number of areas for improvement both at the hospital and in the Ramsay group; 37% of staff stated that they were satisfied with the physical environment in which they worked, 38% of staff stated that the senior management team modelled the Ramsay way and 16% of staff stated that the corporate leadership team listened and acted upon employees views and concerns. There were however some positive

results with 95% of staff stating that they understood the impact that their work had on delivering patient care and 99% stating that they always worked in the best interests of patients and colleagues.

- The senior management team told us that they were shocked and upset by the results of the survey. They told us that at the time of the staff survey there was a great deal of change at the hospital and that they thought that this was reflected in the survey. In response to the survey results they set up a staff engagement group which focused on charitable events and minor day to day issues as opposed to understanding the responses of the staff and putting actions in place to address the staff issues. However the staff and the senior management team were positive about this group and the impact it was having.
- We held two focus groups as part of the inspection process, which were well attended by 78 hospital staff who said that they were positive about working at the hospital and told us that there had been a great deal of improvement following the survey. The hospital had undertaken a staff friends and family test to test improvements in September 2016, this was very positive.
- From our interviews we found that a number of additional actions had been taken in response to the survey but these were not formally recorded in an action plan or the risk register but were seen during the inspection.
- Managers engaged with staff by maintaining a visible presence and publishing regular newsletters. The latest newsletter shared information about new staff, learning from incidents, announcements and patient feedback.
- On the ward staff also had access to a 'feedback' noticeboard displaying important information about compliments, complaints and incidents.
- The hospital did a number of patient satisfaction surveys which included friends and family and a leaflet that was given to patients called "we value your opinion". There was also a patient feedback group. The patient satisfaction scores were some of the highest in the Ramsay group.

Innovation, improvement and sustainability

• The theatre manager described being in the early stages of potential involvement in the use of robotic equipment during surgery. This was being reviewed in partnership with a local NHS trust.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

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-r

We rated safe as good because:-

Incidents

- There was an electronic system in place to report incidents with triggers to alert senior management. Staff told us they felt confident to report incidents and feedback was shared in minutes and team meetings.
- From July 2015 to June 2016, there were no never events, serious incidents or ionising radiation incidents. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic barriers are available at a senior level and should have been implemented by all healthcare providers.
- There were a total of 28 clinical incidents for out-patient department (OPD) and diagnostic imaging between July 2015 and June 2016 (18% of the total clinical incidents for the hospital). The rate of clinical incidents was lower than the rate of other independent acute hospitals we hold this type of data for in the same reporting period.
- There were a total of 25 non–clinical incidents between July 2015 and June 2016 (40% of the total non-clinical incidents for the hospital). The rate of non-clinical incidents was higher than the rate of other independent acute hospitals we hold this type of data for in the same reporting period.
- There was a 'pause and check' system in place in diagnostics as an additional check prior to a procedure to protect patients.
- Feedback from incidents was shared at team meetings, via the clinical effectiveness committee. Staff had access to computers and could check emails during their shift. Examples of lessons learned were provided during the inspection for out-patients and diagnostic imaging.
- Staff we spoke with were familiar with the term 'Duty of Candour'. (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).

Cleanliness, infection control and hygiene

- There were no methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (c. diff) or Escherichia coli (E.coli) reported by the service between July 2015 and June 2016.
- The reception area, consultation rooms and treatment areas were visibly clean and well organised. Housekeeping staff reported that floors were being cleaned, however; they were concerned that the floors were not drying quickly enough in busy corridors.
- Wall-mounted hand gel and sanitizers were readily available on entry to clinical areas and staff we

observed used sanitizing hand gels and hand washing procedures prior to providing patient care. All staff we observed adhered to the 'bare below the elbows' policy in clinical areas.

- Personal protective equipment (PPE) was readily available and included gloves and aprons. Posters displaying 'hand washing techniques' were displayed throughout the hospital.
- Cleaning schedules were in place and clearly displayed. Equipment included "I am clean" stickers. All privacy curtains seen included dates when last changed that were all recent. A third party company monitored sharps bins. They were all secure and not over filled.
- Staff told us, and provided examples, that if a patient presented with a communicable disease, the appointment, either in outpatients or diagnostic imaging, would be allocated at the end of the clinic list. A deep clean of the room would take place following the consultation or treatment.
- There was no dedicated area, in outpatients, noted on the announced inspection, for the cleaning of endoscopes for ear, nose and throat (ENT) procedures, except for the consulting room. On the unannounced inspection, a wall – mounted airflow box was due to be fitted to store the scopes. The processes were explained and staff were considering including the room formerly utilised as the treatment room as part of the decontamination processes.
- Regional infection prevention and control meetings were held every three months. Action plans were included as well as reviews of actions from previous meetings.
- Hand hygiene audits were carried out. In July 2015, there was a compliance score of 91%. There was 100% compliance in October 2015, 96% in December 2015 and 96% in April 2016.
- Infection prevention and control environmental audits were carried out for ward, outpatient and physiotherapy areas. In August 2015, there was a compliance score of 83%, compliance was 80% in November 2015, 88% in February 2016 and 90% in May 2016.There were action plans in place following each audit.
- Infection prevention and control environmental audits carried out, every six months, for diagnostics scored 100% compliance in July 2015 and 98% in January 2016.
- A patient-led assessment of the care environment (PLACE) audit between February 2016 and June 2016 scored 98% for cleanliness which was the same as the England average.

Environment and equipment

- The service was located in a two storey grade II listed building. The outpatient department included six consulting rooms, one treatment room and two pre-operative assessment rooms. Diagnostic imaging included one main x-ray room, one ultrasound room and one mammography room. The physiotherapy department included three treatment rooms, three treatment bays and a gymnasium. These were all located on the ground floor.
- All waiting areas we inspected, were free from clutter, light and had adequate seating available.
- Staff we spoke with, in all areas, told us there was appropriate and adequate equipment available for consultations and treatments.
- Maintenance arrangements were in place to ensure that specialist equipment in the outpatient and diagnostic areas were serviced and maintained as needed.
- There was clear signage in each area including no entry signs in x-ray controlled areas. There were also 'pause and check' posters displayed in diagnostic areas.
- Diagnostic imaging staff displayed meters to monitor radiation doses. These were processed by a third party externally and results fed back to the hospital. The radiation protection supervisor was supported by a radiation protection advisor who was based in a NHS Trust.
- Emergency resuscitation equipment was available in the physiotherapy department. The contents of the trolley were secured with a tag. There were daily checks carried out for items not tagged. There was a full weekly check of the trolley. It was found that emergency medication (amiodarone for treating irregular heartbeats) stored in the trolley was out of date. This

was addressed on-site and the expired items were promptly removed and replaced with in-date medication. In addition a change to the standard operating procedure was immediately implemented.

- In the locked store room, accessed by a key pad, in the outpatient office, there were 'eclipse' white needles that were out-of-date (expired May 2016). In diagnostic imaging a box of chlorhexidine (cleaning) wipes had also expired. Both incidents were addressed on site and the items removed immediately.
- Cytology pots were found, in outpatients without expiry dates. This was addressed and the pots seen on the unannounced inspection all included in- date expiry dates.
- Oxygen cylinders were stored securely, in all areas inspected, and accessible if required.
- In x-ray there were plans to refurbish the office. This included changing the position of the reception staff to improve the viewing and booking in of patients, on arrival. There were also plans to address storage space in the mammography room by removing equipment no longer used.
- A patient-led assessment of the care environment (PLACE) audit between February 2016 and June 2016 scored 88% for condition, appearance and maintenance which was lower than the England average of 93%. The audit scored 69% for disability which was lower than the England average of 81%.

Medicines

- There were processes in place for management and storage of medicines in the outpatient and diagnostic imaging departments.
- There was no on-site pharmacy provision. A service level agreement (SLA) was in place with a neighbouring acute NHS Trust. Pharmacists visited at designated times to monitor the stock levels.
- Any medicines were stored appropriately in locked cupboards and there was no controlled drugs or intravenous fluids stored in any area. There were no patient group directives (PGD's) in place for medication. On the unannounced inspection, medicines stored in secure office cupboards had been relocated to the room previously utilised as a treatment room where the temperature was cooler.
- The x-ray department also stored medicines securely for the mobile scanners whilst they were on-site.
- Fridges that stored medicines were checked daily including the maximum and minimum ranges. Staff had identified that fridge, and room temperatures had not been recorded accurately. The pharmacy, at the neighbouring trust quarantined all medication involved, provided guidance to staff and were monitoring recordings. At the time of the unannounced inspection, fridge medicines remained quarantined.
- A 'safe and secure medication' audit, for June and July 2016, in x-ray scored 100% compliance and OPD scored 100% in June and 94% in July (There were three omissions in daily fridge checks).
- Prescribing audits were carried out, every six months that included both inpatients and outpatients. There was 93% compliance in November 2015 and May 2016.

Records

- Patient records were made up of a combination of paper records and electronic records.
- There was limited space at the hospital for storage of records although they had recently been relocated from the cellar to out buildings.There were greater numbers of shelving and records in place by the unannounced inspection. The medical records offices were secured with keys, on the announced inspection but had transferred to a key pad system by the time of the unannounced inspection. There was CCTV coverage outside. There were fire alarms and cylinders in situ and the attics of the buildings had been 'fire – proofed' by the time of the unannounced inspection. A window was transparent, with records visible, however; this was addressed at the announced inspection and the window opaque by the unannounced inspection.
- Storage of records in outpatients had recently been relocated into an alternative lockable cupboard that was easier to access for staff.
- Diagnostic imaging records were maintained electronically. Administration staff in diagnostics were

responsible not only for hospital appointments but also supported the mobile scanner vans in appointments for magnetic resonance imaging (MRI) and computerised tomography (CT) scans at the locality.

- Since June 2016, the hospital told us that 99.4% of patient records were available at time of appointments. If records were not available, we were told that temporary records were prepared from information saved electronically. Records were merged once retrieved.
- The hospital told us that removal of medical records was strictly monitored. Records held at another Ramsay hospital, were transported using the hospitals transport service in a sealed bag. Records needed for satellite clinics were transported in a secure box, for the duration of the clinic then brought back to the hospital.
- Following patient discharge, records were archived and held in a secure off – site storage facility by a third party company.
- We reviewed ten outpatient paper records, eight physiotherapy paper records, three physiotherapy consent forms and electronic radiology records. All records reviewed were clear and legible, however; five of the outpatient records that were for a follow-up clinic did not include discharge summaries.
- Audits of medical records were carried out every three months. In July 2015, there was a compliance of 93%, in October 2015 and, January 2016 there was 95%, in April 2016 there was 96% compliance and in July 2016 it was 93%. Summaries and action plans were included in each audit.

Safeguarding

- There were no safeguarding incidents reported to the Care Quality Commission between July 2015 and June 2016.
- Policies included a chaperone policy, safeguarding adults and safeguarding children and young persons. The legislation "working together to safeguard children" is not referenced, however; female genital mutilation (FGM), child sexual exploitation *(CSE) and Prevent are included.
- Safeguarding leads were available locally and regionally for support for adults and children and young people.
- Safeguarding information was displayed on office noticeboards.
- Mandatory training included safeguarding training to level two for adults for health care assistants and level three for registered staff in outpatients and radiology. In physiotherapy, the lead was level three trained with other staff trained to level two. Staff were either fully compliant with training requirements or booked to attend.
- Staff, we spoke with, were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately.
- There was no system identified in records that alerted staff if a patient was vulnerable or had a previous safeguarding concerned.

Mandatory training

- Mandatory training was delivered using face-to-face training and e learning.
- Staff received training in areas that included resuscitation, moving and handling, safeguarding, fire safety and infection control.
- Training records showed that all staff were either fully compliant with mandatory requirements or were booked to attend. There had been a postponement in training due to unforeseen circumstances.

Assessing and responding to patient risk

- We observed reception staff confirming the identity of patients on arrival to the departments.
- Care pathways were in place that included details of care and treatment at each stage of the appointment.
- Registered staff attended training for immediate life support (ILS); health care assistants received basic life support (BLS) training as part of mandatory training requirements.
- The physiotherapy department had a resuscitation trolley in place with emergency equipment and medication that included an anaphylaxis kit.

Good

Outpatients and diagnostic imaging

- Outpatients stored an emergency anaphylaxis box in a store room, accessed by a 'key pad' in the office. It was transported to a consulting room during 'allergy – testing' clinics and also the ward were informed when a clinic was taking place in case of an emergency.
- The emergency resuscitation equipment, for outpatients and diagnostics, was shared with the ward. Emergency call bells were accessible in all areas. If pressed, the ward staff attended with the resuscitation trolley. The treatment room, in outpatients, had been assessed, in the event of an emergency situation, as unable to access with the trolley but that resuscitation could begin and the patient be transferred to a larger area. A scenario was observed during the inspection to demonstrate how a patient could be treated in an emergency situation.
- There were concerns raised that the treatment room was too small to treat patients in an emergency. Following the announced inspection, the treatment room was re – located into a larger room to allow any resuscitation to continue in one location. There were plans to include additional equipment such as an oxygen mask and bag and portable defibrillator in order to commence resuscitation prior to the arrival of the resuscitation trolley. We were told that a scenario had taken place, following the re – location with results of improved responsiveness.
- We were told that this was a temporary room and there were plans to re – locate the room long – term. Staff told us that patients who had been treated in both locations were positive about the move.
- If a patient presented a concern, observations of vital signs would be taken. The resident medical officer (RMO) and consultants were available if needed.
- There was an escalation policy in place. Staff we spoke to knew how to escalate concerns about a deteriorating patient. There were service level agreements (SLA) in place with neighbouring acute NHS trust hospitals if emergency care and treatment were required. No patients had been transferred from outpatient and diagnostic areas in the last 12 months.
- In diagnostics, the World Health Organisation (WHO) safety checklist for radiological interventions was in place. (This is adapted from the National Patient Safety Agency (NPSA) surgical checklist to detect any potential error before it leads to harm). The National Safety Standards for Invasive Procedures (NatSSIPs) was in the process of being implemented, however; not routinely in place at time of inspection.
- If a concern was identified on patient radiological scans or X ray films, radiologists carried out urgent reporting and referral to the consultant if required.

Nursing staffing

- Registered nurses and healthcare assistants were employed in outpatients (and satellite clinics), radiographers were in diagnostics and physiotherapy included physiotherapists and support staff. Each area was supported by administration staff.
- For outpatient and diagnostic departments there was a ratio of nurse to health care assistant of 2.1 to 1.
- In outpatients and diagnostics, there were 16 staff: 12.66 full time equivalent (FTE) registered nurses and six health care assistants (six FTE)
- In outpatients between July 2015 and June 2016, there was an average 7.43% registered nurses bank or agency per month and 4.06% health care assistants.
- For outpatient nurses the bank to agency ratio was 25 to 1.There had been no bank and agency health care assistants working in the outpatient departments in the last three months of the reporting period (July 2015 to June 2016)
- Use of bank and agency nurses in outpatient departments was lower than the average of other independent acute hospitals we hold this type of data for in the reporting period (Jul 2015 to Jun 2016), except for in January 2016 and May 2016 when the rates were higher than the average.
- Use of bank and agency health care assistants in outpatient departments was 0% or lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for in May 2016 when the rate was higher than the average.
- Sickness rates for outpatient nurses were variable when compared to the average of other independent acute

Good

Outpatients and diagnostic imaging

hospitals we hold this type of data for in the reporting period (July 2015 to June 2016). Sickness rates were higher than the average in September 2015, October 2015, December 2015 and January 2016.

- Sickness rates for outpatient health care assistants were variable when compared to the average of other independent acute hospitals we hold this type of data for in the same reporting period. Sickness rates were higher than the average in October 2015, January 2016, February 2016, May 2016 and June 2016.
- Between July 2015 and June 2016, sickness rates for registered nurses averaged 6.17% per month and 5.64% for health care assistants.
- The service reported 15.8% staff turnover for clinical staff and 4.4% staff turnover for non-clinical staff in the reporting period (July 2015 to June 2016).
- There were no vacancies for outpatient staff as at 1 July 2016. Training records showed that all staff in outpatients and diagnostics had received an induction.
- Radiologists and radiographers provided an on call cover for any emergency diagnostic intervention

Medical staffing

Refer to surgery section

- There were also ten radiologists employed, in diagnostics, by practising privileges arrangements on a rota basis. We were told that this worked well.

Emergency awareness and training

Refer to surgery section

- There were business continuity plans in place at a corporate and local level with clear instructions for staff to follow in the event of a major incident.
- Staff we spoke with were aware of major incident plans. An example of implementation of the plan was provided during the inspection: a flood occurred at a weekend affecting the x-ray department and record storage.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective. Our findings were:-

Evidence-based care and treatment

- Care and treatment was evidence-based and provided in line with best practice guidance including the National Institute for Health and Care Excellence (NICE). Examples were provided during the inspection.
- Standard operating procedures (SOP's) were in place to support staff and there was a process in place to review and update these based on latest national guidance.
- The radiation protection advisor, (RPA) based in a NHS Trust, audited the diagnostics department annually and produced an action plan if needed.
- The RPA provided support and was accessible and provided feedback that Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) guidelines were being followed well.
- The World Health Organisation (WHO), safety checklist was in place for radiological interventions.

Pain relief

- Staff told us that it was rare for pain relief to be required, although; a prescription could be created and the medicine obtained.

Nutrition and hydration

- There were water coolers and drinks machines available in the outpatient waiting areas.
- Staff provided hot drinks and biscuits if appointments were delayed.
- We were told that meals could be sourced for patients if needed, for example patients with diabetes.
- Staff told us there was a good choice of quality food at affordable prices.
- At the unannounced inspection the lift was out of order. This meant it was difficult for transporting meals from the lower ground floor kitchen to the patients above.

Good

Outpatients and diagnostic imaging

- A patient-led assessment of the care environment (PLACE) audit between February 2016 and June 2016 scored 92% for organisational food which was higher than the England average of 91%.

Patient outcomes

- A corporate audit programme was in place with quarterly clinical governance audit report produced that included audit activity and action plans at each location.
- Monthly audits were completed in physiotherapy, with emphasis on a variety of aspects of the service. There was 100% compliance, in audits for delivering a safe and effective service, in August 2015 and August 2016, as well as learning and development and working in partnership with patients in October 2015. There was also 100% compliance in promoting physiotherapy services and products in May 2016.
- In physiotherapy, a patient records keeping audit, in July 2015, scored 85%. An action plan was put in place with a re-audit in January 2016 and an improved score of 99%.
- An audit of consent in physiotherapy scored 92%, in February 2016. An audit of an evaluation of clinical services in March 2016 scored 96%. An audit of physiotherapeutic treatment, in April 2016 scored 96% compliance. Action plans were in place for audits that scored less than 100%.
- Audits of referral forms, in diagnostic imaging, to gain assurance of compliance with IR (ME) R and best practice guidelines between July 2015 and April 2016 all scored 100% compliance.
- Audits post examination, in diagnostics, to gain assurance of compliance with IR (M) ER and best practice guidelines, between September 2015 and July 2016 were 100% compliant.
- An annual audit of non–medical referrers, in March 2016, scored 100% compliance. A non- radiologist reported imaging audit, in July 2016 was 100% compliant. An annual audit of all patient services undertaking exposure to ionising radiation scored a compliance of 93%.
- Audits completed, in July 2015 and January 2016 on procedures performed in theatre under x-ray control scored 100% compliance.
- Diagnostic imaging monitored the numbers of rejected images. Between August 2015 and November 2016, 3% of the total images were rejected.

Competent staff

- Staff were supported in their development using the appraisal process, which was undertaken annually. These were linked to the values of the provider.
- All outpatient health care assistants had had their appraisals completed in the current appraisals year so far (July 2016 to June 2017).
- More than 88% of outpatient nurses had had their appraisal completed in the appraisals year so far (July 2016 to June 2017).
- Staff completed competencies relevant to their roles in each department. In addition, records of compliance with Provision and Use of Work Equipment Regulations 1998 (PUWER) were in place.
- Staff told us they felt supported to develop their skills including academic qualifications and the Ramsay scholarship.
- There was a process in place for practising privileges. Consultants submitted application packs with relevant documentation and were interviewed and reviewed by senior management before being accepted. Copies of appraisals were obtained annually with review of privileges every five years.

Multidisciplinary working

- All staff we spoke with told us that departments worked well together and supported each other across departments.
- A daily huddle occurred each lunchtime with representatives attending from each department.
- There were service level agreements in place for certain departments that included pharmacy and laboratory services that worked well.
- There were processes in place to refer to social services, for example if physiotherapy considered that additional equipment was required.

Good

Outpatients and diagnostic imaging

Access to information

- Staff accessed information from the trusts electronic systems, intranet and paper records that were readily available.
- The radiology department used picture archive communication system (PACS) to store and share images
- Policies and procedures were available on the trusts intranet where the most current versions were stored.
- Following consultations, staff completed discharge letters that were forwarded to patients and their G.P.'s.We were told this could be two to three weeks following consultations due to the demands of the service. A set of five paper records were reviewed prior to an evening clinic. All patients were attending for follow–up appointments, however; there were no discharge summaries included in the records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The consent policy provided guidance about gaining consent for all patients that including those who may lack capacity to consent to treatment.
- Mandatory training included Mental Capacity Act (MCA) and Deprivation of Liberties (DOL's).
- Information about mental capacity and deprivation of liberties was displayed on office noticeboards.
- Consent forms for three patients in physiotherapy were reviewed and had been completed appropriately.
- Audits of consent were carried out every three months. In September 2015, there was a compliance of 95%; it was 91% in December 2015, 93% in March 2016 and 90% in June 2016. All audits included summaries and action plans.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:-

Compassionate care

- We observed that patients were treated with respect and promptly in reception. Patients were greeted at the reception desk and directed to the appropriate area to wait. Patients were escorted from waiting areas to consulting rooms individually with members of staff allocated to a list of patients.
- Privacy and dignity of patients was maintained during consultations. They took place in individual closed rooms in both outpatients and diagnostics. Consulting rooms included either a privacy curtain or additional examination rooms. Chaperone posters were displayed in consulting rooms and nurses attended the appointments.
- Patients, we spoke with, were very positive about the care they received from all staff. Thank you cards, received from patients were displayed in office areas.
- The NHS friends and family test (FFT) rates were good between January 2016 and June 2016. The percentage of patients who would recommend outpatients and diagnostics was between 98% and 100%, with response rates between 4% and 8% for NHS patients. For private patients the percentage of patients who would recommend were the same with response rates between 4% and 7%.
- Minutes from management meetings, showed that any negative comments or feedback from the latest FFT results, were discussed including the low response rates.
- A patient-led assessment of the care environment (PLACE) audit between February 2016 and June 2016 scored 85% for privacy, dignity and well-being which was higher than the England average of 83%.

Understanding and involvement of patients and those close to them

- Patients could be seen in clinic with those close to them if preferred as well as a chaperone.
- A variety of leaflets were available in the waiting area containing information specific to certain conditions or treatments.
- All patients we spoke with were very positive about the information they received.
- Patients were informed and were understanding about any short delays in waiting for consultations.

Good

Outpatients and diagnostic imaging

Emotional support

- We saw staff interacting positively with patients in each department. In outpatients a nurse was observed supporting a patient who was visibly distressed in a very respectful manner.
- Nurses with special interests cared for certain patients and provided continuity and emotional support for patients.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:-

Service planning and delivery to meet the needs of local people

- The outpatient services included both NHS and self-funded patients with the majority of patients referred from G.P.'s in the NHS. The main hospital site was supported by three satellite clinics for patients that were eligible to attend in those geographical locations.
- The service was located in a semi–rural area but also close to a main road with public transport links. Its location was in between a number of NHS trust hospitals and there were service level agreements in place, for some services that included pharmacy and phlebotomy with neighbouring trusts.
- We were told that patients with co-morbidities may be seen in outpatient areas, however; any further intervention such as surgery, may need to be referred back to a local trust if medical staff assessed that all patients needs could not be met at the hospital.
- Staff told us that there had been technical difficulties with the phone systems, when patients tried contacting the hospital, however; a dedicated 'switchboard operator' had recently been appointed to answer patient calls.

Access and flow

- There were 26,662 outpatient total attendances in the reporting period (Jul 15 to Jun 16); of these 84% were NHS funded and 16% were self-funded. There were 11,335 NHS first attendances in outpatients and 11,066 follow up appointments (ratio 1:1). There were 1,769 self-funded attendances in outpatients and 2,492 follow up appointments (ratio 1: 1.4). Attendances for satellite clinics were recorded in all outpatient data rather than individual sites.
- The booking staff in the OPD produced an exception report when there were insufficient slots for out-patients and in response to this additional clinics were put on to meet the demand following negotiation with the consultants.
- Details of waiting times from arrival in the departments until appointments were requested, however; the provider did not capture this data.
- Details of any cancellations were requested, however; the provider did not capture this data. In addition, details of any clinic overruns were requested, however; the provider did not capture this data. Staff told us that clinics were usually busy and well attended and often finished late.
- The provider met the referral to treatment time (RTT) target of 92% of patients on incomplete pathways waiting 18 weeks or less from time of referral in the reporting period (July 2015 to June 2016).
- Above 95% of patients started non-admitted treatment within 18 weeks of referral in the reporting period (July 2015 to June 2016).
- The hospital had no patients waiting six weeks or longer from referral for ultrasound scans in the reporting period (July 2015 to June 2016).
- Radiology monitored did not attend rates (DNA) monthly. Between January 2015 and November 2016, the DNA rates were between 0% and 4%.

Meeting people's individual needs

- There was clear signage outside and inside the hospital directing patients appropriately. Once in the waiting rooms, patients were escorted to consultations.
- Waiting rooms with ample seats were available. Radiology patients shared the waiting room with outpatient clinic patients. There were televisions displaying news channels with subtitles. There were vending machines for drinks and snacks as well as newspapers, magazines and toilet facilities.

Good

Outpatients and diagnostic imaging

- An additional 'premier lounge' waiting area was available for self-funded patients that included a television, reading material, complimentary hot drinks and toilet facilities.
- There was a car park that was free of charge and also close to a main road, with public transport, and near to motorway links.
- The main entrance was accessible for patients / carers with reduced mobility and disabled toilet facilities were available.
- There were 'one stop' clinics available for some conditions and diagnoses, such as breast clinics, where patients could have investigations, consultations and be supported physically and emotionally in one visit.
- There were also gender specific clinics held for certain investigations.
- Interpreters and an interpreting service were available if needed. Leaflets were available for a variety of conditions and could be translated in languages other than English if required. Large formats were also available for individuals with visual impairment.
- There was bariatric equipment available if needed that included weighing scales for specialist clinics.
- On inspection, an example was provided of utilising skills of an individual who was fluent in sign language to translate for a patient during consultations.
- The hospital had been commissioned to provide care to patients with dementia. Dementia champions were displayed on office noticeboards and 'This is me' documentation was in place.
- There was no system to highlight, in records, if a patient with a special need such as a learning disability was attending the clinics, however; an example was provided of a patient who was supported by the same staff on each visit. Initially the patient was distant from the staff but a relationship developed where the patient became very close to the staff.
- There was a large physiotherapy department, however; no other therapies were offered at the hospital.

Learning from complaints and concerns

- There were six complaints between February 2016 and July 2016. These were managed according to the level of investigation required. Actions from each were taken and all had been resolved with the patients.
- Minutes from the management meetings, showed that complaints were shared and discussed as learning opportunities.
- There was information displayed, throughout the hospital to inform patients how to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:-

Vision and strategy for this this core service

Refer to surgery section.

- There were individual departmental visions and strategies that were aligned with the hospitals vision of "... to be safe, effective and deliver a good experience." The "Northern Blitz Spirit" focussed on 'our people' and how everyone contributed to the development of the hospital.
- Each departmental office clearly displayed their vision and strategy that was adapted for each area. All staff we spoke with were familiar with them. Staff discussed their understanding of the hospital values and the strategic plan as part of the appraisal process.

Governance, risk management and quality measurement

Refer to surgery section.

- A medical physics expert was available to offer advice and support based at the 'Radiological Protection Centre' in a trust nationally for the radiology service.
- There were clinical effectiveness committee meetings held every three months and all hospital activity was reviewed including any governance issues, incidents, feedback from patients, the risk register and any actions required.

Good

Outpatients and diagnostic imaging

- Clinical governance meetings were held monthly that reported operational issues and action plans. Senior management team (SMT) meetings and departmental management team (DMT) meetings were held monthly. Any agreed actions were reviewed at subsequent meetings.
- Medical advisory committee (MAC) meetings were held. There was a process in place for consultant practising privileges. Doctors submitted an application pack that included copies of training certificates, references, evidence of indemnity insurance, check that on GMC register, DBS check and occupational health check. Doctors were interviewed by senior managers and then the application reviewed by the medical advisory committee and group medical director before being accepted.
- Sickness rates for outpatient registered nurses varied and higher than the average in September 2015, October 2015, December 2015 and January 2016. Sickness rates for health care assistants were higher than the average in October 2015, January 2016, February 2016, May 2016 and June 2016. Bank nurses were employed to provide cover when needed.

Leadership and culture of service

- There were clear regional and local management structures in place that identified lines of accountability. We found managers responsive to feedback in order to improve patient care.
- There were clearly defined and visible leadership in place in outpatients, diagnostics and physiotherapy areas. We were told that with the ever increasing capacity within the departments that additional management support could be beneficial in some areas in order to maintain the high standards of care and treatment to all outpatients.
- All staff we spoke with felt supported by their departmental managers. They felt supported to learn and develop. They were appraised annually with objectives that were aligned with corporate values.
- There was an open culture and staff told us they sought support across departments in the hospital and all staff we spoke to liked working at the hospital.
- Staff were very positive about their own departments and the hospital with many having worked there for several years.
- We were told that there was great team spirit and they very much enjoyed working there. They were able to provide a high standard of care and treatment to all their patients.

Public and staff engagement.

Refer to surgery section

- Outpatient and diagnostic departments participated in the NHS Friends and Family Test (FFT) and information about how patients and those close to them could provide feedback was displayed in waiting areas.
- Following the staff survey, earlier this year, the employee engagement action group had initiated a number of fund raising activities.
- Many staff members participated in a charity bike ride too, in the hospital grounds, from Lands' End to John O'Groats. Staff also held regular bake sales for charity.
- The hospital sponsored a local children's football team; all the kit required was provided to the team.
- Managers organised several seasonal events that included a summer barbeque and Christmas dinner as well as the distribution of Easter eggs, ice creams and toffee apples.
- Staff that parked off site were eligible for a free lunch and showers were available for cyclists. Tea and coffee was free to staff.
- Staff that worked late, such as housekeeping cleaning in theatres, could use a taxi service to travel home.
- Staff had access to a monthly newsletter and could also use social media. Staff could be nominated for awards that included 'end of month madness'.
- Physiotherapists facilitated Pilate's classes that were accessible for staff.
- Heads of departments had attended away day learning experiences and staff had access to private health care.
- Staff representatives from each department attended a daily 'huddle' at 12:15pm where hospital items were discussed.

Good

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- Sustainability was discussed at management meetings. The majority of the hospital capacity was NHS patients that had increased over recent years.
- As a grade II listed building, there had been a number of environmental improvements externally as well as internal improvements that included new flooring. There were plans for on- going maintenance tasks.
- The hospital was very responsive to patient feedback that was provided by senior managers.

Outstanding practice and areas for improvement

Outstanding practice

- 'One stop' clinics were available for certain conditions such as breast care with positive feedback from patients about the care and treatment provided.
- Pilates classes were available in physiotherapy for patients and staff.
- Managers had responded well to the results of the staff survey.

Areas for improvement

Action the provider SHOULD take to improve

- Have a process in place to identify, in patient records, any patient with a current or previous safeguarding concern.
- Change the area for specimen storage in the theatre area from a box on top of other items to a more stable area.
- Have a process to identify patients, in records, with a special need such as a learning disability.
- Monitor storage to ensure maximum use of limited space and only essential equipment stored.
- Have a process to check expiry dates on surgical equipment and remove out of date equipment to limit the potential risk of out of date equipment being used.
- Improve the central risk register to become a tool that manages risk across the hospital.
- Undertake root cause analyses for appropriate investigation reports.
- Grade incidents correctly so that duty of candour is applied appropriately.
- Respond to complaints in a timely manner.
- Audit of compliance of National Institute of Clinical Effectiveness (NICE) guidance.
- Clinical representation from the medical advisory committee on the clinical governance committee.