Fitzwilliam 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Fitzwilliam Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 41 beds. Facilities include three main theatres with laminar flow, a purpose built ambulatory care unit and a day case unit.

The hospital provides surgery, services for children and young people, and outpatients and diagnostic imaging. We inspected each of these services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 15 November 2016 along with an unannounced visit to the hospital on 29 November 2016

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

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

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

Services we rate

We rated this hospital as good overall.

We found good practice in relation to surgery, outpatient and diagnostic care:

- Staff had access to a variety of comprehensive policy documents referencing best practice and legislation and there were mechanisms in place to audit staff compliance to policy. The hospital participated in national and local patient outcome audits. The hospital had joint advisory group (JAG) accreditation for endoscopy services.
- Staff reported good multidisciplinary working with the ward staff, outpatients, theatres, and physiotherapy.
- The hospital managed practicing privileges in line with appropriate guidance, staff checks, and timescales.
- The outpatients and surgery referral to treatment times (RTT) were better than the England average. Patients could attend evening and weekend appointments to promote access to treatment for patients who have work or family commitments. Private patients could be seen in as little as 72 hours following referral.
- Staff knew and understood the hospital vision and values. The hospital had a clear governance structure; staff received feedback via team meetings, emails, and shared information boards across the hospital. Staff spoke highly and were supportive of the leadership style of managers.

We found areas of practice that require improvement in services for surgery, outpatient and diagnostic imaging:

- Venous-thromboembolism risk assessments were not always available in patient records.
- The staff completion rate for safeguarding children training at level three was very low at 9%. The completion rate of advanced life support training for theatre staff was 40%.
- We were not assured regarding the staffing arrangements for patients under the age of 18 years of age having surgery.
- Patient information was misfiled within patient's healthcare records, making it difficult for staff to find key documents relating to patients care, assessment, or treatment. Whilst consultants routinely signed patient healthcare records where they had provided care, advice, or treatment, they did not print their name nor date the record they had completed. We found that in five of the seven patient healthcare records we reviewed there were no consultant notes available.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. We also issued the provider with one requirement notice that affected surgery in respect of young people's services and outpatients in respect of patient records. Details are at the end of the report.

Professor Ted Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. The Fitzwilliam hospital offered surgical procedures to privately insured, self-paying and NHS funded patients. The hospital had 41 single patient rooms and two double patient rooms, all with ensuite bathrooms within the inpatient ward to support day case surgery and overnight stays. Privately funded patient rooms were decorated to a higher specification with carpet flooring. In addition, the hospital had three theatres with laminar flow, ambulatory care unit with ten trolleys and a day surgery suite with three trolleys and a theatre facility. The hospital admitted 10,839 patients aged 18 and over, between July 2015 and June 2016. Of these 2,408 were for day case surgery and 8,431 were overnight stays. The service undertook 15 surgeries on patients aged between 16 and 18 years of age. We have therefore included children's services under the surgery section of this report. This is because the service provided to children and young people is a very small part of the main running of the service.
Outpatients and diagnostic imaging	Good 	The outpatient department at Fitzwilliam Hospital had 16 consultation rooms and three treatment rooms providing patient clinics, a health screening service, and a private general practitioner (GP) service. There were a range of speciality services available including: gastroenterology, cardiology, gynaecology, breast, and general surgery amongst others. There was a minor procedures room, ear nose and throat suite and a physiotherapy suite. The diagnostic imaging department offered magnetic resonance imaging (MRI), computerised tomography (CT), ultrasound, fluoroscopy, mammography, and general x-rays.

Summary of findings

The hospital provided consultation and treatment for aged 16 and 17 years of age and adults. The outpatient department operated between 8am and 8.30pm Monday to Friday, and on a Saturday from 8am to 4pm.

Between July 2015 and June 2016, 77,046 patients attended the outpatient department, 1,144 were children up to 17 years of age, and 75,902 were adults. Sixty-three percent of the total attendances were NHS funded patients, and 37% either self-funded or funded from other sources, for example, private insurance claims. The service ceased providing outpatients to children under the age of 16 from June 2016.

The hospital had an onsite pharmacist and patients could access this service during outpatient clinic hours. Staff had access to a Resident Medical Officer (RMO) 24 hours a day, seven days a week for support and guidance on medication and the management of patients who may become unwell during treatment.

Summary of findings

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Fitzwilliam Hospital

Services we looked at

Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to Fitzwilliam Hospital

Fitzwilliam Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1983. It is a private hospital in Peterborough, Cambridgeshire. The hospital primarily serves the communities of Peterborough and the surrounding area.

The hospital is registered to provide the regulated activities of:

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

The hospital has had a registered manager in post since 1 October 2010.

Our inspection team

The team that inspected the service was led by a CQC Inspection Manager, and included four CQC inspectors and one specialist advisor who was a consultant grade doctor with a background in surgery.

Information about Fitzwilliam Hospital

Fitzwilliam Hospital is a purpose-built hospital with three main theatres with laminar flow, a purpose-built ambulatory care unit and a day case unit with general anaesthetic facility.

The hospital offers a full range of specialties with orthopaedics representing the largest proportion. Orthopaedic surgeons cover main sub-specialties for upper and lower limb together with spinal sub-specialities. A physiotherapy unit with gym and treatment rooms is available with a long standing outreach physiotherapy clinic for self-funded patients located at a GP surgery in Stamford.

The radiology department has a static MRI facility which was commissioned in 2013. The department also comprises of two x-ray rooms, mammography, ultrasound and a mobile CT (Ramsay Imaging).

The outpatient department has 16 consultation clinic rooms and three treatment rooms providing patient clinics, a health screening service combined with private GP services.

The hospital has benefited from a proactive investment programme totalling in excess of £6m in the last five years. A further major development has been approved to commence works in October 2016 for an additional main theatre, theatre equipment store, refurbished physiotherapy department with a larger gym facility, an additional three new outpatient clinic room rooms, a new two-bedded HDU, further development to the reception waiting area, additional administration space and patient parking.

During the inspection, we visited all departments and the ward. We spoke with 34 members of staff including; registered nurses, health care assistants, radiography staff, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and one relative. During our inspection, we reviewed 22 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in January 2014 which found that the hospital/service was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 – June 2016):

- There were 10,858 inpatient and day case episodes of care recorded at the hospital

Summary of this inspection

- Of these, 78% were NHS funded and 22% were other funded.
- 21% of all NHS funded patients and 27% of all other funded patients stayed overnight at the hospital during this period.
- There were 77,046 outpatient total attendances in the reporting period (Jul 15 to Jun 16); of these 63% were NHS funded and 37% were other funded.

There were 141 doctors practising at the hospital under practising privileges. There were 50.2 full time equivalent (FTE) registered nursing or midwifery staff; 21.2 FTE health care assistants and operating department practitioners; and 98.5 FTE other hospital staff. There was a resident medical officer (RMO). The accountable officer for controlled drugs (CDs) was the registered manager as of 6 January 2016.

Track record on safety:

- No never events reported
- 506 clinical incidents; 432 with no harm, 46 low harm, and 28 moderate harm.
- The provider reported six serious injuries in the reporting period.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- Two incidences of hospital acquired E-Coli
- 59 complaints, one of which was referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service).

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAGS) accreditation

Services provided at the hospital under service level agreement:

- Pharmacy
- Blood Bank
- Histopathology
- Infection Control Chair
- Pathology

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Venous-thromboembolism risk assessments were not always available in patient records. Patient records were incomplete due to missing notes of the initial pre-operative assessment with a surgeon.
- The staff completion rate for safeguarding children training at level three was very low at 9%.
- The completion rate of advanced life support training for theatre staff was 40%.
- Surgical site infection rates were high with 26 surgical site infections reported between July 2015 and June 2016.
- We were not assured regarding the staffing arrangements for patients under the age of 18 years of age having surgery.
- Patient information was misfiled within patient's healthcare records, making it difficult for staff to find key documents relating to patients care, assessment, or treatment.
- Whilst consultants routinely signed patient healthcare records where they had provided care, advice, or treatment, they did not print their name nor date the record they had completed.

Are services effective?

Good

We rated effective as good because:

- Staff had access to a variety of comprehensive policy documents referencing best practice and legislation and there were mechanisms in place to audit staff compliance to policy.
- Patient pain, nutrition, and hydration needs were assessed and addressed by staff.
- The hospital participated in national and local patient outcome audits.
- The hospital provided services to patients seven days a week and had access to diagnostic services out of hours and weekends.
- The hospital had joint advisory group (JAG) accreditation for endoscopy services.
- Staff reported good multidisciplinary working with the ward staff, outpatients, theatres, and physiotherapy.
- The hospital managed practicing privileges in line with appropriate guidance, staff checks, and timescales.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Patients praised the staff their commitment to care and consistently told us that they were kind and compassionate.
- Patients told us that staff had kept them informed about their care.
- Patients and staff had access to support from specialist nurses.
- The hospital Friends and Family Test (FFT) results between January 2016 and June 2016 showed that between 96%-100% of people would recommend the service to friends and family. This was higher than the England average.

Are services responsive?

Good

We rated responsive as good because:

- The hospital planned staffing and resources to meet the needs of patients.
- Staff and patients had access to specialist service to ensure their individual needs were met.
- The hospital had a robust complaints process and learning from complaints was shared with staff.
- Private patients could be seen in as little as 72 hours following referral.
- On average over 90% of NHS patients were admitted for treatment within 18 weeks of referral between July 2015 and June 2016.
- The outpatients department staff developed a partnership with a local service that provided fertility treatment to the public in order to fast track patients for surgery where possible, to reduce waiting times and improve the prospects of fertility.
- The outpatients department exceeded its target of 92% for referral to treatment (RTT) waiting times in less than 18 weeks for the period July 2015 to June 2016 for incomplete patients. These figures related to NHS funded patients only.
- Patients could attend evening and weekend appointments to promote access to treatment for patients who have work or family commitments.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew and understood the hospital vision and values.
- The hospital had a clear governance structure; staff received feedback via team meetings, emails, and shared information boards across the hospital.

Summary of this inspection

- There was an up-to-date risk register in place. Staff knew the risks identified, who was responsible for mitigating the risks and the actions taken by the hospital to address any risks likely to affect patient or staff safety.Where further risks were identified the hospital put immediate steps in place to address these.
- Staff said managers locally were instrumental in providing leadership that inspired them, gave clear guidance, and were supportive whilst encouraging a culture of shared knowledge and experience to provide patients with care and treatment that met their needs.
- The hospital provided a wide range of opportunities for staff and patient engagement to support continuous service improvement.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Requires improvement

Incidents

- Surgery services had no never events 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, at a national level, and should have been implemented by all healthcare providers.
- The hospital reported six serious incidents between July 2015 and June 2016. The number of serious incidents was not high compared to other acute hospitals.
- The hospital had no recorded deaths between July 2015 and June 2016.
- The hospital reported 506 clinical incidents between July 2015 and June 2016. Of these incidents 234 (46%) occurred in surgery or inpatient services. All of the incidents were no harm (85%), low harm (9.1%) or moderate harm (5.5%) and no severe harm or death occurred following a reported incident.
- The hospital reported 83 non-clinical incidents between July 2015 and June 2016, 39 (47%) occurred in surgery and inpatient services.
- The hospital staff used an electronic incident reporting system and all staff had access to the system. The provider had an incident reporting policy in place for staff to follow which outlined staff responsibilities and risk classification.
- We spoke with four staff members about incident reporting and they all reported that they knew how to report an incident and had access to the electronic reporting system. All four staff members gave an example of incidents that had been reported for example potential drug errors and patient falls. They also told us that they had feedback about incidents in monthly team meetings.
- We spoke with the theatre manager and the ward manager about incident reporting and they both told us that they encouraged staff to report any situation of concern to be investigated. They reported that they shared feedback on learning from incidents to staff at monthly team meetings.
- We reviewed the minutes of the theatre team meeting and the ward team meeting for July 2016 and saw that incidents were discussed at these meetings.
- We reviewed the minutes of the medical advisory committee (MAC) meeting for July 2016 and noted that incidents were discussed.
- We reviewed the MAC meeting minutes for May 2016 and July 2016 and the committee discussed patient morbidity and mortality.

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

- Clinical quality data and safety thermometer data were not displayed in the ward. However, the hospital supplied the safety thermometer data from October 2015 to October 2016. The hospital reported that they had no pressure ulcers, falls with harm, catheter acquired urinary tract infections during this time.

- Data supplied by the hospital showed that four patients had developed a deep vein thrombosis or pulmonary embolus following a surgical procedure between May 2015 and December 2016. The hospital reported that all four cases were investigated and an action plan was in place following a root cause analysis of each of the reported event. No further incidents were reported after December 2015.

Cleanliness, infection control and hygiene

- The hospital had no reported incidents of methicillin resistant staphylococcus aureus (MRSA) or methicillin sensitive staphylococcus aureus (MSSA) between July 2015 and June 2016.
- The hospital had no reported incidents of clostridium difficile (C-diff) between July 2015 and June 2016.
- The hospital had two reported incidents of E-coli between July 2015 and June 2016.
- The hospital reported 26 surgical site infections between July 2015 and June 2016. The surgical site infection rate for primary hip arthroplasty, primary knee arthroplasty, upper gastro-intestinal colorectal and urological procedures was above the rate of other independent acute hospitals.
- The hospital had investigated all of the surgical site infections reported and found no common link in the theatre used or surgeons and the infection type differed in each individual case.
- The surgical site infection rate for other orthopaedic and gynaecological surgeries was similar to other acute independent hospitals. The hospital had no reported surgical site infections resulting from breast cranial and vascular procedures.
- All areas of the theatre department were visibly clean. We reviewed the theatre cleaning schedules in each of the three theatres and in all cases the cleaning records showed staff had completed cleaning. Staff had signed the records on the completion of cleaning and there were no gaps in the records for November 2016.
- The three inpatient theatres had laminar flow units in place. The theatre manager reported that orthopaedic surgeries took place in all three theatres to optimise theatre utilisation and that all of the theatres were cleaned thoroughly between each theatre list.
- The hospital had 41 single rooms and two double rooms, one of which is used for close patient monitoring. All rooms had ensuite bathrooms. Twenty-two bedrooms had carpet flooring and eight of these were used for NHS patients. The deep cleaning schedules for the patient bedrooms showed each room was deep cleaned on a yearly basis; the remainder of the rooms had vinyl flooring.
- Staff wore uniforms with short sleeves and followed the bare below the elbows policy. In addition, staff wore gloves and aprons appropriately while providing patient care and disposed of these correctly.
- We observed staff washing their hands after providing care to patients and using hand sanitising gel appropriately.
- Staff cleaned equipment on the ward and a dated green sticker was placed on all items after cleaning.
- We observed advice being given to a 16 year old patient and their guardian, regarding cleaning of their physiotherapy equipment whilst at home. This helped maintain hygiene and infection control.
- Staff had access to an infection prevention and control policy and in addition hand hygiene, and MRSA screening policies were available to staff on the hospital intranet.
- We reviewed the results of the hand hygiene audit undertaken in August 2016 and the inpatients department scored 97% compliance with the provider hand hygiene policy.
- The hospital had a service level agreement with a local NHS trust for the decontamination of surgical instruments. The theatre staff had the ability to track surgical instrument cleaning electronically through the barcoded system in place. The hospital had two deliveries of decontaminated equipment and two collections of contaminated equipment per day.

Environment and equipment

- Patients were cared for in ensuite private rooms, all rooms had telephones, wall mounted televisions and cupboards to store patient belongings. The hospital had 14 separate bedrooms for privately funded patient and

26 bedrooms allocated to NHS patients. The bedrooms for privately funded patients were to a higher specification, all having carpet flooring and more storage for patient belongings.

- Resuscitation trolleys were available in the theatre recovery and in the ward. The resuscitation trolleys were sealed with a breakable tag with a unique identification number which was recorded in the records.
- We checked the contents of the resuscitation trolley in theatre recovery. The listed equipment was present and in good working order and single use items were within their expiry date.
- We reviewed the records for the resuscitation trolley checks in the theatre recovery and there were no gaps in records for April, May, June, July, August, September, and October 2016.
- We reviewed the records for the resuscitation trolley on the ward and saw gaps for the daily check on the 23 and 30 September 2016, 6 and 9 October 2016. There were no gaps in the daily checks during August 2016 and November 2016. The weekly checks were complete for August, September, October, and November 2016. The trolleys were stocked with appropriate equipment, and the defibrillator had been checked.
- We sampled 35 single use items within theatres and 10 items on the ward. We found that all items were within the expiry date and stored appropriately.
- We checked six electrical items within the operating department including one anaesthetic machine. Four items had up-to-date testing labels, one label was blank, and one label was illegible. The theatre manager kept an up-to-date equipment register and we saw that all equipment was within their testing dates.
- The equipment register for the ward and the records showed that all equipment was up-to-date with safety testing.On the ward we checked eight patient controlled analgesia pumps, three infusion pumps and one ECG machine and all of the equipment was up-to-date with safety testing.
- Implant registers were kept in each theatre; the implant record books and implants were recorded with patient details for traceability. In addition, the theatre manager archived completed implant register books securely within their office.
- The hospital staff had access to one patient hoist shared across all services; the hoist had a maximum working load of 200 kilograms. Bariatric equipment such as beds, commodes, and chairs were available when required within the hospital.
- The hospital had an eye laser located within the out-patient department. The laser had an external audit in October 2016, which judged the laser safety and environment to be good. The laser was up-to-date with safety testing. The local rules for the use of the laser were up-to-date and staff had signed the register to evidence the rules had been read.

Medicines

- The hospital kept medicines in rooms secured with a keypad entry in both the ward and the theatre department. Controlled drugs were kept in double locked metal cupboards in the anaesthetic room of each theatre.
- We checked the controlled drugs in theatre one and in the inpatient ward. In both cases the stock levels matched the records and all medications were within their expiry dates.
- We reviewed the controlled drugs audit for June 2016 and the hospital scored 97% compliance with internal policy.
- We observed staff preparing medicines for administration and staff checking the prescription on the drug record card before selecting the medicine at the correct dosage.
- Medicine fridges were located in each anaesthetic room and the recovery area within the theatre department. We checked the fridges in one anaesthetic room and the recovery area and staff had checked the temperatures daily with no gaps in the records for November 2016.
- We reviewed the fridge temperature reports for August, September and October 2016. The fridge in the anaesthetic room had been out of order in September 2016, and a replacement fridge had been installed. In addition, the recovery fridge had been replaced in September 2016 due to high temperature readings.
- We checked the fridge located in the treatment room, checked the fridge temperatures daily and there were no gaps in the records for November 2016. We reviewed

the fridge temperature reports for August, September and October 2016. These records showed that the medicine fridge located in the ward treatment room was not checked on 16 August 2016, and 7, 8, 9 October 2016.

- The hospital stored blood for transfusion due to the large orthopaedic surgeries undertaken in theatres. The hospital had a service level agreement with the local NHS trust to supply blood for transfusion. The fridge used for blood storage was monitored by the local NHS trust by means of weekly temperature graphs and regular equipment reviews.
- We reviewed the blood transfusion staff training records and the staff competency register and we found the records were up-to-date and we had no concerns.
- We reviewed the medicines management audit carried out in April 2016; the hospital scored 95% compliance with internal policy.
- Young people were prescribed antibiotics in accordance with local antibiotic formularies. All five surgical records we looked at contained the patient's height and weight. This allowed appropriate prescriptions to be made and was in line with the National Institute for Health and Care Excellence (NICE) guidelines QS61.

Records

- The hospital used paper patient records and no records were kept electronically. Staff used paper patient pathway documents to record the inpatient care provided.
- All inpatient medical records were kept within a labelled metal rack in a room secured with a keypad entry. Patient nursing records were kept at the patient bedside.
- We reviewed five patient records and saw that all patients had received a nurse-led pre-operative assessment and staff kept legible accurate contemporaneous records. However, of the three of the records for private patients there was no record of the pre-operative consultation with the surgeon, only the completed booking form. The two NHS patient records included the pre-operative consultation notes.
- Within all five patient records we found that completed risk assessments for falls and pressure ulcers and malnutrition universal scoring tools were complete. However, we found only two patient records contained completed venous-thromboembolism (VTE) risk assessments. We asked a member of staff where the VTE risk assessments were located within the notes and the three cases we could not locate them. We reviewed a further three patient records during our unannounced inspection and found a complete VTE risk assessment in all cases.
- We saw that the World Health Organisation five steps to safer surgery had been completed in all five records we reviewed. We observed this was undertaken in theatre and was undertaken in accordance with requirements.
- Consultants recorded surgical notes following procedures in all five of the records we reviewed. However, five records for private patients (three for cosmetic surgery patients) did not contain notes for the initial pre-operative consultation with a surgeon. Therefore patient records were incomplete and we did not gain assurance through the patient records that cosmetic patients received a two week cooling off period, though processes were in place the records did not always demonstrate this.
- We reviewed five young people's notes from surgery and five from the outpatients department. All were organised and legible.
- We reviewed a children's day case care pathway. This contained a page to assist with emergency calculation of drugs, and recording of the size of equipment required in theatre.
- Since services to children (under 16 years) ceased in August 2016, young adults aged between 16 and 18 years, were treated using adult pathways and care plans. This was in line with national guidance.

Safeguarding

- The data provided by the hospital showed that staff completed all safeguarding training through e-Learning.
- The hospital wide training completion rate for safeguarding adults level two was 87%.
- Safeguarding staff notice boards were on the ward and within the staff rest room in the theatre department. In both areas, the noticeboards displayed comprehensive

information relating to safeguarding adults and children. Safeguarding flow charts were available to guide staff through the local process of raising a safeguarding concern.

- We spoke with the ward manager and the theatre manager who both reported that their staff discussed safeguarding concerns if they needed support.
- We spoke with four members of staff about safeguarding and all staff members referred to the notice boards and gave examples of types of safeguarding concerns they would raise. We asked two members of staff about children's safeguarding. They felt confident in reporting safeguarding concerns, pointed us to the information on the noticeboards and could name the safeguarding leads.
- The hospital's children safeguarding lead was a registered nurse (child branch) who worked at the local NHS hospital. They were contactable via telephone. We noted that their contact number was clearly displayed on notice boards, in the staff's break room, behind reception and in the hospital main corridor. We spoke to a member of staff who had called for safeguarding advice. They described the safeguarding lead as very responsive and lessons learnt from their conversation were discussed and recorded at the department's monthly meeting.
- We reviewed the records of young people who had received surgery. We found that on the days of surgery there was not a registered nurse (child branch) present during all surgeries. This is not in accordance with best practice on the treatment of patients under the age of 18 years of age.
- The hospital had a specific safeguarding policy for children and young people. Staff felt this was easily accessible, as it was available on the computer system and attached to the safeguarding noticeboards.
- We reviewed this policy and found it be comprehensive and up-to-date. This included information on signs of child neglect, abuse, domestic violence, female genital mutilation (FGM), fabricated illness, and child sexual exploitation (CSE). The hospital had guidelines and flow charts detailing signs to look for and how to report concerns. The policy referenced national guidance.
- The policy contained a child specific protection report form to assist staff with reporting concerns.
- We also noted leaflets and information were available for identifying child abuse and raising concerns. This was accessible to both staff and visitors.
- All 110 staff, who had contact with patients aged under 18 years were trained to level 1 children safeguarding, 104 (95%) were trained to level 2, and 10 (9%) were trained to level 3. The hospital had identified level 3 training as an area of improvement and staff are were supported to complete it with the use of a corporate online training programme. The registered nurse (child branch) was trained to level 3 and partially to level 4.
- We requested data regarding safeguarding level 3 in the week following our inspection. There had been an improvement with 49% of ward staff, 54% of theatre staff, and 100% of radiology staff having completed this training.
- The hospital's chaperoning policy stated that a child will always be accompanied by a chaperone and their parent or guardian will be present. Staff told us they ensured this happened, by encouraging parents to attend the recovery ward when the patient woke up. In addition staff from other departments were moved to ensure chaperones were available. We confirmed this by observing a young adult throughout their stay in outpatients. They were always in the presence of a member of staff and their guardian. This ensured the patient was kept safe.

Mandatory training

- The mandatory training programme included the following modules, fire training, basic life support, manual handling, blood transfusion, infection control with aseptic non-touch technique, Intermediate life support, risk management, prevent, calculations assessment, paediatric basic life support and customer care.
- We reviewed the hospital mandatory records published in November 2016, and the completion rate for all staff was 85.9%. However, the completion rate for the prevent module was 70.9% and the 66.9% for paediatric life support.

- The completion rate for all staff with e-Learning was 83%. The service reported that it aimed to ensure that all staff had received mandatory training.
- Mandatory training completion data for the theatre department showed the completion rate for healthcare assistants was 81%, operating department practitioners was 86% and registered nurses 85%. The e-Learning completion rate for the theatre department was 87%.
- The mandatory completion rates for inpatient services were 88% for registered nurses, and 93% for healthcare assistants, which was below the hospital target of 85% compliance.
- We spoke with four members of staff about mandatory training and all of them said they had completed their mandatory training and there were no problems accessing eLearning or mandatory training.

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

- The hospital had admission criteria for patients to ensure patients who underwent surgical procedures were assessed according to risk. We reviewed this document and had no concerns as the document was comprehensive and clear for staff to follow.
- The hospital used the national early warning scores (NEWS). NEWS is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient observations such as heart rate. We reviewed five patient records and all cases we found that the news score were completed appropriately.
- The hospital used the World Health Organisation five steps to safer surgery and found correctly completed check lists in all five patient records reviewed.
- Staff completed the five steps to safer surgery checklist in theatre and all elements were carried correctly.
- The completion rate for basic life support training for the ward and theatre department staff was 86%. In addition 94% of ward staff and 86% of theatre staff had completed intermediate life support training.
- The completion rate of advanced life support training for operating department practitioner staff was 40%. However, this was due to vacancies in the department. There was always a trained person on duty on each shift to support the RMO if required.
- We reviewed five patient records and all of the patients had attended a pre-operative assessment. A nurse had completed a pressure ulcer risk assessment, the malnutrition universal screening tool and health screening for each patient.
- The pre-assessment lead nurse told us that all patients had a pre-operative assessment two weeks before the planned procedure and that that all concerns relating to patients were escalated directly to the surgeon prior to the procedure.
- Two ward nurses had completed advanced life support training and all staff had completed training in intermediate life support. The ward manager told us that the hospital had a formal process to escalate deteriorating patients; this process was used in conjunction with NEWS and included analysis of the situation, patient background, assessment and recommendation (SBAR).
- We spoke to three members of staff about escalating a deteriorating patient and all of them reported that escalation was based on the NEWS and all concerns were escalated to the resident medical officer. They also knew the process to transfer of a critical ill adult and this was in line with the provider policy.
- The hospital had access to a resident medical officer 24 hours a day, seven days a week in the event of an emergency. In addition, the consultants remained on-call until their patients were discharged from the hospital.
- The hospital undertook cosmetic surgery and had measures in place to ensure patients had access to a psychological assessment if this was required. The hospital had two specialist plastic surgery nurses who had access to consultants working under practicing privileges qualified to undertake these assessments.
- The hospital had formalised document to complete in conjunction with escalating a deteriorating patient. The

competed document was inserted into the patient record, the staff knew how to complete the document and to contact the resident medical officer to review a patient of concern.

- The hospital had a service level agreement with the local NHS trust for the transfer of an unwell patient who required intensive care. The hospital had a policy for the transfer of a critically ill adult which contained checklists for staff to use to ensure the process was followed correctly.
- Preoperative assessments were carried out by a paediatric surgeon or registered nurse (Child branch) in line with NICE guidance.
- Young people in surgery were assessed using the same national early warning score tool (NEWS) as adults. This was in line with hospital policy. The operations were undertaken on young people aged 16 to 18 years of age and was seen by the Ramsay Group as safe practice.
- In the event of deteriorating health of a young person, staff would call upon the 24 hour resident medical officer (RMO), as per hospital policy. The RMO was trained in paediatric advanced life support. Staff we spoke to could not recall this ever being required.
- During the inspection we identified concerns regarding the availability of equipment in theatres in the event of a young person's condition deteriorating. Specifically, the airway breathing tubes were not stocked in the smaller sizes for young people. The provider took action to temporarily suspend operations on young people for two days until equipment required was stocked and available. This did not result in any cancelled operations.

Nursing and support staffing

- The hospital reported that senior staff had an awareness of the Shelford model acuity tool, however staffing was planned according to the expected patient admissions. We reviewed the documents used to plan staffing levels and had no concerns.
- The theatre manager told us that theatres had three whole time equivalent operating department practitioner vacancies.
- The ward manager reported that the ward had two whole equivalent nurse vacancies and one whole equivalent healthcare assistant vacancy.
- The rate of bank and agency staff usage for the theatre department was over 30% from December 2015 to June 2016 for registered nurses. The bank and agency usage rate for healthcare assistants and operating department practitioners (ODP) was below 5% between July 2015 and June 2016.
- The theatre manager told us that the agency usage rate was high due to the regular use of three agency theatre staff every week due to ongoing unfilled vacancies.
- The bank and agency staff usage rate for inpatient registered nurses was between 5% and 13% for the period July 2015 to July 2016. The bank and agency rate for inpatient healthcare assistants under 7% for the same period except for June 2016 where the rate rose to 9%.
- There were no unfilled shifts within the inpatient services and the theatre department between April 2016 and July 2016.
- Data provided by the hospital showed the vacancy rate for registered nurses was 0.2% and for healthcare assistants and ODP's was 16% in July 2016.
- The inpatients services had a vacancy rate of 0.05% for registered nurses and 0.5% for healthcare assistants.
- We observed the handover of a patient from the ward staff to the theatre staff, correct relevant information was shared between staff.
- The ward staff had handovers at each staff shift change where patient care needs were discussed. In addition, the ward manager told us that night staff updated handover sheets for the following day.
- We spoke with the ward manager about maintaining staff competencies and they reported that staff from the ward rotated into the day surgery unit. They told us that rotating staff between the two areas maintain competencies for all staff in both clinical.
- The hospital did not have a registered nurse (child branch), one from the local NHS hospital worked at the hospital on a set day. Therefore we were not assured that Royal College of Nursing guidelines were being followed, which, state there should be two registered

nurses (child branch) were present during day surgery, for patients under 18 years of age at all times during surgery and recovery. The service reported that they were following the Ramsay Healthcare Group policy on staffing in relation to the care and treatment of patients under the age of 18 years of age.

- These guidelines also stated a minimum of one registered nurse (child branch) must be available at all times to assist, supervise, support and chaperone patients under 18. The registered nurse (child branch) confirmed they would visit the hospital two Fridays a month, when possible. They stated that they had telephone consultations for all 16-18 year old patients, to access weather the patient required a pre-assessment to be carried out by the registered nurse (child branch).
- A department manager was unable to provide information on the procedure, if the registered nurse (child branch) was absent, such as being on annual leave or off sick. Hospital staff were unable to provide risk assessments or polices regarding this. We asked the registered nurse (child branch) about these arrangements and they stated the staff were 'more than competent' in their absence.

Medical staffing

- The hospital had 160 consultants working under practicing privileges. Practicing privileges were granted to consultants following medical advisory committee review of supporting clinical evidence supplied by a new applicant. Final approval of practicing privileges was granted by director of the provider group.
- The hospital reported that 10 consultants had practicing privileges removed between July 2015 and June 2016. Three consultants retired, one consultant moved out of area, one consultant requested removal, one consultant was no longer providing services at the hospital and four consultants failed to provide the requited documentation.
- The hospital had a contract with an agency to supply registered medical officers. The resident medical officers (RMO) were on-call 24 hours a day for urgent calls. The RMO worked to a rota of seven days of 24-hour cover followed by seven rest days. We spoke with one RMO who confirmed this.
- The RMO's received handover briefing at the beginning of their shift which highlighted any concerns or required jobs.
- We spoke with one RMO about their role and they reported that their duties were to assess and check pre-operative patients, assess post-operative patients, check patient test results and assess un-well patients. They also said that consultants and anaesthetists were easy to contact.
- Consultants remain on-call for the duration of their patients inpatient stay in hospital. In addition, the consultant arranged cover for any holiday and other leave to ensure patients had a nominated consultant to oversee their care.
- Anaesthetists attending to patients during their procedure remained on-call for 24-hours following the surgery in the event of an emergency. Following this period, the hospital on-call anaesthetist attended in the event of an emergency.

Emergency awareness and training

- The hospital had regular fire evacuation tests for staff. We spoke with two members of staff who confirmed this.

Are surgery services effective?

Good

Evidence-based care and treatment

- The hospital had a variety of policies available to staff through the hospital intranet. We spoke with four members of staff about access to policies and all reported they had access to the policies and demonstrated how to access the policies.
- We reviewed hospital policy documents for example, the hand hygiene policy, and consent to treatment for competent adults and children and young people. In both cases, we found the documents were up-to-date with a specified review date and referenced best practice and national guidance.
- The hospital undertook regular audits to monitor staff compliance with organisational policies; these included

the controlled drugs audit and hand hygiene audit. The hospital reported that local audit performance was benchmarked against other hospitals within the provider group.

- The hospital had facilities to monitor a patient closely following surgical procedures. Critical care was not provided by the hospital, though there were two double rooms, which allowed for a higher level of close observations for post surgery or unwell patients. The hospital transferred adults that were unwell to the local NHS hospital.
- The hospital was measured against commissioning for quality and innovation (CQUIN) standards set out by the local clinical commission groups for NHS patients. CQUIN's are a measure of improvement in quality of services and better outcomes for patients.
- The hospital had joint advisory group (JAG) accreditation for endoscopy services.
- Policies relating to children and young people were up to date and referenced best practice guidance and legislation. These included the department of health, general medical council and royal college of surgeons. This ensured policies and procedures had the most up to date national guidance for staff to follow.
- There were no specific audits relating to children and young people. One member of staff told us that this was due to this age bracket being a very small proportion of their patients (less than 1%).

Pain relief

- Pain assessment tools were embedded in national early warning scores. Staff completed assessment at regular intervals depending on patient acuity. The five medical records we reviewed reflected that staff completed regular pain assessments and patient received consultant prescribed pain relief.
- The ward manager told us that 11 of the ward nurses had recently attended a pain management training session facilitated by an external speaker.
- We spoke with four patients about pain and both patients told us that the nursing staff asked about their pain regularly. They both reported that their pain was managed well by the staff.
- Anaesthetists prescribed post-operative pain relief for patients to ensure they had adequate pain relief. We reviewed five drug prescription records and each case in each post-operative pain relief was prescribed.
- The hospital had a pain management consultant who worked under practicing privileges.

Nutrition and hydration

- We reviewed five drug prescription records and in all cases, patients were prescribed anti sickness medicines where appropriate. We spoke with two patients about nausea and both told us that they had not had any problems.
- All patients received advice about pre-operative starvation times in their pre-operative assessment and in a letter sent to the patient with fasting instructions. All patients were advised not to eat for six hours prior to surgery and only to drink water until two hours before the surgery. This could be flexed dependent on patient need and any delays to surgery.

Patient outcomes

- The hospital participated in patient reported outcome measures (PROM's) for NHS patients who had primary knee replacements, primary hip replacements, and groin hernia procedures.
- The hospital Oxford knee score showed that 91.7% of patients reported an improvement. The Oxford hip score showed that 97.4% of patients reported an improvement.
- We spoke with the theatre manager and the ward manager about patient outcomes and they both reported that the hospital participated in the PROM's and they did not participate in any other national audits.
- Venous Thromboembolism (VTE) audits completed and shared with us showed a compliance rate of 96% with the service's policy on VTE.
- The hospital had ten unplanned re-admissions and 18 unplanned transfers to another hospital between July 2015 and June 2016.
- The hospital had 11 unplanned cases that returned to theatre between July 2015 and June 2016.

- We reviewed the patient led assessments of care environment (PLACE) score for the hospital between February 2016 and June 2016. The hospital scored higher than the England average for cleanliness, condition appearance and maintenance, dementia, disability organisational food and ward food. However, privacy dignity and wellbeing scored 78%, which is lower than the England average of 83%.
- The hospital reported that internal processes were in place to provide data to the Private Healthcare Information Network (PHIN). They also reported that data was submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).

Competent Staff

- The hospital required consultants to provide documented evidence of responsible officer appraisal and revalidation in order to maintain practicing privileges. Data provided by the hospital showed that four consultants had practicing privileges removed between July 2015 and June 2016 because this evidence was not submitted.
- The hospital used agency resident medical officers (RMO). Each RMO was required to produce evidence mandatory training for example advanced life support training. The RMO's also completed a local induction process.
- Data provided by the hospital showed that 100% of theatre staff had received an appraisal between July 2015 and June 2016. The data also showed that 77% of inpatient nursing staff and 67% of health care assistants had received appraisals for the same period.
- We spoke with the ward manager about staff appraisals and they reported that there were two appraisals still to complete, one member of staff was absent from work due to long term sickness and the other was booked to take place after our inspection.
- The theatre manager told us that 100% of appraisals were complete for theatre staff.
- We spoke with seven members of staff about appraisal and all of the staff reported that they had received and appraisal in the last months.
- The theatre manager told us that new staff had a competency based preceptorship and partnered with an experienced member of staff. The preceptorship period was six months with regular meetings between the new member of staff and the theatre manager to review competency completion. In addition, we saw completed staff competency documents for theatre staff and had no concerns.
- Ward staff had completed competencies in intravenous drug administration, infection prevention, post-operative care, blood transfusion and patient controlled analgesia.
- All staff who had contact with children and young people had completed competencies in caring for children. We reviewed these and all were up to date and signed by the registered nurse (child branch). The registered nurse (child branch) confirmed they had signed these and had no concerns with staff competence.

Multidisciplinary working

- There was effective communication between the theatre staff and the ward staff during a patient handover. In addition, we observed a member of the ward nursing staff and a physiotherapist discussing a patient's progress.
- We spoke with the theatre manager about multidisciplinary working and he reported that the theatre team regularly liaised with porters and ward nursing staff during patient handovers. In addition, theatre staff had regular discussions with administrative staff regarding bookings, consultants, and anaesthetists during procedures.
- One of the resident medical officers told us they were in regular contact with the ward nursing staff throughout the course of a day and was able to contact consultants at any time.
- The pre-assessment lead reported that they had access to discuss patients with their general practitioner (GP) and consults if they required further information or had concerns.
- Discharge planning for patients started at the pre-operative assessment and staff liaised with community service if extra support was required following a patient discharge.

- Discharge letters were hand written by the resident medical officer in triplicate on a carbon copy proforma. The patients were responsible for the delivery of the discharge letter to their GP. Staff gave an additional copy of the discharge letter to patients to take home for their own records.

Seven-day services

- Resident medical officers were on-call 24 hours a day seven days a week. One of the resident medical officers told us that they were able to contact consultants if they had concerns about their patients.
- The hospital pharmacist was available Monday to Friday between 9am and 5pm with 24-hour on-call pharmacist support outside these hours. Medicines were obtained via SLA from the local NHS trust pharmacy for hospital non-stock items for patients to take home on discharge.
- The hospital had an on-call system for surgeons and physicians in place and utilised a buddy system for holidays and other leave. The surgeon or physician advised who was in charge of their patients in their absence.
- The hospital had an on-call rota for anaesthetists. However, the anaesthetist present during the surgical procedure was responsible for their patient for the 24 hours following surgery.
- The hospital had access to radiography and radiologists out of hours and at weekends on an on-call basis.
- The hospital had on site physiotherapy services and provided care tailored to the needs of the inpatients seven day a week.

Access to information

- Staff had access to patient records, kept in a room with keypad entry and nursing records were kept at the patient bedside.
- Staff had access to policies required to undertake their roles. They could access all documents through computers or through folders stored on the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to the provider policies relating to the mental capacity act and deprivation of liberty safeguards the through the hospital intranet.
- Data provided by the hospital showed that the eLearning module for safeguarding adults level two covered the mental capacity act and deprivation of liberty safeguards. We saw that 87% of staff had completed the eLearning module and 47% of staff had completed the face-to-face training for the mental capacity act and deprivation of liberty safeguards.
- We spoke with two heads of department who told us that patients had mental capacity assessment during the pre-operative assessment process if this was required. They reported that patient consent forms were signed prior to admission. They both told us they had not needed to implement a deprivation of liberty safeguard during their employment at the hospital.
- The ward manager gave us an example of room allocation for a recent patient with mild dementia. The patient was allocated a room close to the nurse's station for closer observation following surgery.
- We reviewed five patient records and all completed consent forms were signed by the patient and the consultant.
- We reviewed three records for cosmetic surgery patients and all cases the notes for the initial out-patient assessment with the surgeon were missing. Therefore, we were not able to be fully assured that people received a two week cooling off period. Although staff were able to describe activities they undertook to ensure patients did receive the cooling off period.
- The hospital worked to a policy titled 'consent to treatment for competent adults and young people'. This policy had guidance on the concept of Gillick competence that takes into consideration a child's increasing development to maturity and their ability to consent to some procedures, but not others. Principles of Fraser were also outlined, allowing a young person to obtain sexual and reproductive advice, without their parents or guardians knowledge, if the healthcare professional deems it appropriate.
- The hospital only provided services to patients aged 16 years and over, staff stated that their ability to consent was assumed, unless they had reason to think otherwise, this was in line with their policy and the Royal College of Nursing guidance.

Good

Surgery

- Each set of patient notes we reviewed contained an information sheet with this guidance and all 16-18 years olds had provided consent. We also observed that the parent and guardian was present and involved, which was considered good practice by national guidance.

Are surgery services caring?

Good

Compassionate care

- Staff were kind in their approach to the delivery of patient care, using appropriate language to ensure patients understood what was going to happen.
- The theatre department and the inpatient ward were quiet and calm. Staff ensured that patients were at the centre of the care provided.
- Staff maintained the privacy and dignity of their patients, doors to patient rooms were closed during the delivery of personal care. However, the patient led assessments of care environment (PLACE) score for privacy dignity and wellbeing scored 78% and which was below the England average of 83%. The managers were exploring why the rates from this survey were low.
- One patient told us that they had been looked after very well by the ward staff and felt they had received good quality care. They praised the nursing staff for their commitment to patient care.
- One patient said, “The care is excellent and out of this world, staff are very friendly, caring and nothing is too much trouble”.
- Another patient told us that the staff had treated them with respect and kindness and that the nursing staff responded to their needs quickly.
- We reviewed the results of the hospital Friends and Family Test (FFT) results between January 2016 and June 2016. The results showed that patients said they would recommend this hospital to their friend and family was 100% March and April 2016, 99% for January and May 2016, 98% for June 2016 and 95% for February 2016.
- We requested specific patient feedback relating to children and young people’s services. The hospital reviewed all patient feedback, friends and family responses, insurer feedback, concerns and complaints between July 2015 and June 2016. There was no feedback specifically relating to the paediatric and young people admissions.

Understanding and involvement of patients and those close to them

- The ward allocated named nurses to patients for each shift. Two patients told us that staff introduced themselves at the beginning of their shift.
- The hospital’s patient charter made reference that care was provided by a friendly, efficient team who ensured patients were involved in decisions about their treatment. Patients were given information that ensured patients were well-informed about your choices, provided in easy understand format.
- Four patients told us they had been fully informed about the process of the surgical procedure and the expected recovery time.
- One of the patients told us that they had problems prior to admission as they were booked into the wrong clinic and had to chase the administration staff for information and the correct booking. However, they said that the quality of care they received during their inpatient stay made up for the problems encountered prior to her admission.

Emotional support

- Patients and staff had access to support from a dementia nurse specialist and the outpatient department lead for additional support for patients with learning difficulties.
- The hospital’s patient charter included reference to staff understanding and recognising patient’s social and cultural diversity, values and beliefs.
- The hospital had two specialist plastic surgery nurses who completed pre-operative assessments for plastic surgery patients. The nurses also supported plastic surgery patients on the ward and any outpatient follow up.
- One patient told us that staff had made arrangements for their seven year old daughter to visit in the evenings

to reduce theirs and their daughter's anxiety. They were able to give the daughter emotional support during their inpatient stay which helped to relieve their anxiety about being away from home.

- Another patient told us that they had been anxious before surgery and a member of staff had sat with them until the procedure to give reassurance.
- One patient said, "staff have been supportive and take their time, I have not felt rushed".

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital offered services for private and NHS patients. Privately funded patients had access to treatment by general practitioner (GP) referral or by self-referral for treatment. NHS patients were referred to the hospital by either a GP on an NHS consultant.
- The hospital worked closely with the local clinical commissioning groups to offer NHS patient care, 77.6% of admissions between April 2015 and March 2016 were NHS funded patients.
- The hospital offered bookings to private patients for their procedure at a time that suited them. The hospital advertised that private patients could be seen in as little as 72 hours following referral.

Access and flow

- The hospital booked procedures in advance and did not accept emergency patients for surgery. This allowed the hospital to plan staffing levels and resources to meet the needs of the expected patient numbers.
- The hospital had admission criteria for patients to patients who underwent surgical procedures were assessed according to risk. There was a comprehensive exclusion criteria set by the hospital to ensure high risk patients were not accepted for surgical procedures.
- All admissions were agreed with the admitting consultant and patients were health screening in a nurse lead pre-assessment consultation prior to the procedure.
- Over 90% of patients were admitted for treatment within 18 weeks of referral between July 2015 and June 2016, except for April 2016 where 86% received treatment within 18 weeks.
- The hospital did not accept emergency admissions for surgical procedures. However, in some cases patients needed to return to theatre due to an unexpected complication. The theatre manager told us that staff worked to an on-call rota out of hours to provide a core theatre team in the event of a return to theatre.
- We spoke to three members of staff about unplanned returns to theatre and all of them told us that all unplanned returns to theatre are reported as an incident. The ward manager reported that all unplanned returns to theatre were investigated and a majority of cases were due to post-operative haematomas.
- Staff gave a discharge summary to patients prior to leaving the hospital after a procedure. The patient was responsible for delivering the discharge summary to their general practitioner.
- The hospital reported 135 procedures were cancelled within the last 12 months and 118 (87%) patients were offered another appointment within 28 days of the appointment being cancelled.

Meeting people's individual needs

- The hospital had a learning disabilities link nurse and the outpatient department manager had extended their role to support staff and patients with learning disabilities.
- The hospital had access to a specialist dementia nurse, to provide support to staff in order to meet the needs of patients living with dementia. The ward manager gave an example how room allocation was adjusted to ensure a patient living with mild dementia was visible from the nurse's station. This was to ensure the patient could see the staff if they became disorientated following their surgical procedure.

Good

Surgery

- The hospital had access to a translation service for patients whose first language was not English. One member of staff told us that translators were booked to attend the hospital to give face-to-face support to patients and staff. They also told us that the telephone translation service was used infrequently and was an option in an emergency.
- The hospital reported that individual patient needs were taken into account when planning and delivering services. Patient specific requirements were documented at the pre-operative assessment in the patient pathway document.
- Patients were provided with three meals a day during their stay. The hospital had a kitchen on site to produce freshly cooked food for patients and staff.
- We spoke to two patients about the food and both patients told us that they had a variety of menu options and the food was tasty.
- The ward manager told us that special dietary requirements were recorded in patient records and staff informed the kitchen to ensure these requirements were catered for.
- Patients had access to a water jug at the bedside and staff supplied hot drinks to patients and their relatives during the day. The ward manager told us that in the event of delays in theatre intravenous fluids were given to patients waiting for surgery.

Learning from complaints and concerns

- The hospital received a total of 58 complaints between July 2016 and June 2016, one complaint was referred to the ombudsman during this period. The number of complaints received by the hospital was lower that other independent acute hospitals. The hospital had not broken down the complaints data by department.
- The three main themes of complaints made were about administration communication, clinical care and consultant attitude and behaviour.
- The hospital received no complaints related to the care of children or young people.
- The hospital has a complaints process in place for local resolution. The provider also had a comprehensive policy for staff to follow. The matron and the quality improvement manager were responsible for co-ordination and oversight of complaints investigation. The heads of department investigated complaints and gathered the required statements and evidence.
- The hospital sent a written response to patients within 20 working days of the receipt of the complaint. In addition, if the hospital was unable to respond within the set time a letter was sent to the patient to advise them of the delay and the reasons why.
- The ward manager told us that they investigated complaints related to inpatient services and shared the learning with staff. We reviewed the minutes for the monthly head of department meeting for June and July 2016 where complaints were discussed. We reviewed the minutes for the medical advisory committee meetings for May and July 2016 where complaints were also discussed.
- We spoke with three members of staff about complaints and all of them felt able to manage a complaint or concerns raised by patients and felt able to escalate any complex issues to their line manager. All of the staff members reported that they received feedback about complaints either in the monthly team meetings or one-to-one with their line manager.
- Leaflets containing patient information about complaints were available on the ward. Information about complaints was on the hospital website and patients were able to submit feedback and complaints through the hospital website.
- The hospital manager and matron told us that learning from incidents and complaints were shared with the other hospitals in the provider group. They gave examples of learning they had discussed with staff following an incident at another hospital to ensure best practice was followed by staff.

Are surgery services well-led?

Good

Vision and strategy for this this core service

- The hospital vision aimed for the hospital to be the premier provider of health in the local area, and to offer high quality safe patient centred care.

- The theatre manager told us that the strategy for the department was to embed the principles of compassion in practice (Department of Health, 2012) into staff culture.
- The ward manager told us that they worked toward the hospital vision and strategy with their respective staff.

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

- The hospital had a clear governance structure in place with appropriate arrangements for communication. The hospital had committees such as clinical governance, senior management, and heads of department, which fed into the medical advisory committee (MAC).
- We review the meeting minutes of the last two MAC meetings. The meetings were attended by the majority of all key specialities and actions and outcomes were documented. Key items of risks and any items escalated from other groups or committees were discussed.
- We reviewed the minutes of the team meetings for the theatre department and the ward and saw that the heads of department shared quality and governance information with staff. Notice boards with governance information were located on the ward and within the theatre department staff restroom.
- We reviewed the ward risk register; this had eight risks documented for the clinical area. The risks were up-to-date with an appropriate action plan for all risks. The ward manager showed us the active risk assessments for the ward.
- The risk register did not identify some key issues regarding the care for children under the age of 18 years during surgery. This was identified as part of the inspection process and had not been identified by the service prior to this inspection.
- The theatre manager told us that the risks for the theatre department were recorded on the main hospital risk register and theatres did not hold a separate risk register. They knew the risks related to the department and had copies of risk assessments held on the risk register.
- Staff we spoke with confirmed that information relating to quality, risk, and governance was shared in team meetings.

Leadership / culture of service related to this core service

- The theatre department and the ward had dedicated managers that reported to the hospital matron. The theatre manager was supported by a deputy theatre manager and a theatre co-ordinator and the ward manager was supported by sisters and a senior staff nurse.
- The theatre manager and the ward manager told us that they were proud of their staff for their commitment and dedication. In addition, they reported that they facilitated staff progression with clinical supervision and education.
- Staff in the theatre department and the ward reported that they felt valued and well supported by their manager. They told us that they were able to raise concerns openly and both managers had an open door policy.
- The theatre manager and the ward managers told us that they were well supported by the hospital matron and they were visible to staff. Staff told us that felt able to approach the matron with concerns.

Public and staff engagement

- The hospital had a variety of mechanisms to gain feedback from patients by means of the friends and family test, monitoring of twitter and Facebook comments, the online patient survey and through complaints and complements received.
- The hospital held education events on the first Thursday and third Wednesday every month for local general practitioners (GP's) with presentations from consultants on a variety of health topics.
- The hospital also held open events for the public with consultant speakers about procedures offered by the hospital.
- The hospital had mechanisms for staff engagement these included the staff survey, information boards, team meetings and a consultants newsletter. Staff we spoke with told us that communication was good and had the opportunity attend staff social events.

Good

Surgery

- The hospital staff had involvement with local charity events, the hospital manager gave us an example of a recent event where physiotherapy staff volunteered their clinical services the great east run.
- The hospital held staff 'Bitesize' forums, where the general manager invited to discuss issues over lunch.

Innovation, improvement and sustainability

- The ward manager told us that the hospital recently confirmed links with local universities to enable staff to undertake professional development to level eight (PhD). The hospital aimed to develop their-own staff team due to a shortage of nurse with surgical or theatre training.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

Incidents

- The hospital reported 251 clinical incidents within outpatient and diagnostic imaging services between July 2015 and June 2016. This rate of clinical incidents is above the rate of other independent acute health providers and equates to a clinical incident rate of 0.2 per 100 outpatient attendances.
- There had been no never events or serious incidents reported within the outpatient and diagnostic imaging services from July 2015 to the time of our inspection.Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available, at a national level, and should have been implemented by all healthcare providers.
- The hospital reported 30 non-clinical incidents within outpatient and diagnostic imaging services between July 2015 and June 2016. The assessed rate of non-clinical incidents is slightly below the rate of other independent acute providers and equates to a clinical incident rate of 0.08 per 100 outpatient attendances.
- We reviewed five incidents on the hospital electronic recording and reporting system. The hospital thoroughly investigated all of the incidents following a route cause analysis (RCA) approach and feedback provided to staff and any patients involved. The reporting system enabled staff to collate letters, incident reports, and photographic evidence in relation to specific incidents and we could easily track incidents from initial reporting to conclusion.
- All nursing staff, radiographers, and health care assistants we spoke with knew how to report incidents using the hospital electronic reporting system. One member of staff gave an example of using the system to report concerns regarding sharps and another gave an example of reporting faulty equipment.
- We reviewed team meeting minutes dated September 2016, and noted incidents had been shared with the team and actions discussed to reduce incidents reoccurring. A member of the staff from the radiography department told us about learning from an incident that had resulted in a new piece of equipment being trialled to assist patient mobility, and ensure their safety during an examination.
- In radiography, staff had also implemented a pause and stop process before every patient examination started. The staff implemented this process following learning from a previous incident that occurred at another hospital within the Ramsay group. This demonstrated the hospital shared learning from incidents beyond the affected team or hospital.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (2000) (IR(ME)R). Diagnostic imaging services had procedures in place to report incidents to the correct regulators, for example the Care Quality Commission (CQC). There had not been any reportable (IR(ME)R) incidents at this hospital in the past 18 months.

Good

Outpatients and diagnostic imaging

- All staff we spoke with within outpatients and radiology knew their responsibility and the process relating to Duty of Candour. The Duty of Candour is a legal duty on services such as hospitals to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

Cleanliness, infection control, and hygiene

- All staff adhered to the hospital's hand hygiene and "bare below the elbow" policy, and wore personal protective equipment such as gloves and aprons during care and treatment. Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilising the hand sanitizer where appropriate.
- We spoke with two members of staff who explained the protocol for patients with possible infectious disease and demonstrated they had good understanding of infection, prevention, and control in their day-to-day activities with patients. Staff assessed patients were to address any infection risk prior to admission.
- Hand sanitizer was available at the entrance to each corridor area and there were notices reminding staff and visitors to clean their hands when entering or leaving wards or departmental areas. There were also notices at hand washing areas providing information about IPC.
- There was appropriate provision of cleaning materials and housekeeping staff were visible throughout our inspection and continually engaged in cleaning activities. We saw that staff frequently emptied waste bins during the course of the day and the environment was visibly clean.
- We reviewed daily cleaning schedules between July 2016 and November 2016 for the three treatment rooms within the outpatients department. The schedules were complete and signed by staff with no omissions. We reviewed the daily cleaning schedules for the radiology department between August 2016 and November 2016, and found these were also complete.
- Two members of staff told us they had recently completed IPC training. Hospital training records showed IPC training incorporated into mandatory training for all staff.
- The hospital had a dedicated IPC lead that carried out random hand hygiene audits and provided support and guidance to staff on all issues relating to IPC.
- Information displayed on staff information boards showed staff compliance with hand hygiene was 100% in October 2016.
- Clinical waste was disposed of appropriately and in line with the hospital's waste disposal procedures. Staff used yellow clinical waste bags, with foot-operated waste bins, and sharps bins, correctly assembled, signed, dated, and not over-filled.

Environment and equipment

- The hospital had recently refurbished the outpatient department corridor walls as part of its estate refurbishment programme. The corridor areas were bright, well lit, visibly clean, and free from clutter.
- We checked equipment in three treatment rooms and noted all equipment routinely checked and within their respective service or equipment renewal dates. Equipment also displayed "I am clean" stickers to show that staff recently cleaned equipment.
- Patient trolleys, equipment, and curtains providing privacy within the three treatment rooms appeared visibly clean. Curtains displayed an expiry check date and we found all curtains to be within service date and in good condition.
- We found signage around the hospital, outpatients, and radiology areas to be clear and easy to follow.
- Controlled areas within the imaging department had light boxes outside indicating when it was not safe to enter. Access to the magnetic resonance imaging (MRI) suite was via a door locked with a keypad allowing only authorised people to access the controlled areas, and reception staff escorted all patients to the MRI suite.
- The outpatient team utilised three treatment rooms and a reception area to meet patients on arrival. The outpatient department had 16 consultation clinic rooms; these were a combination of half carpet in the seated area and half vinyl in the examination area. All treatment rooms had vinyl flooring which is in accordance with best practice guidelines.

Good

Outpatients and diagnostic imaging

- There was no specific equipment within outpatient areas for resuscitation. However, the ward area, situated close to the outpatient department, did have resuscitation equipment for both adults and children, which outpatient staff could access if required.
- Equipment stored in cupboards was clearly labelled and stored safely.
- Radiology staff used lead aprons to protect themselves against unintended radiation exposure. Lead aprons were in good condition and were checked on a regular basis and replaced when not fit for purpose. Thyroid protection shields were available in theatres and the fluoroscopy room in line with IR(ME)R recommendations.
- An external supplier serviced and maintained diagnostic imaging equipment for the hospital. The service schedule showed that all imaging equipment received an annual service.
- Radiographers wore film badges to measure radiation doses and the hospital monitored these quarterly to ensure radiation exposure remained within acceptable limits.
- We spoke with staff who explained the methods used to maintain and rotate stock to ensure it was up to date and ready for use.
- Staff segregated waste appropriately and stored this according to hospital policy, staff maintained sharps bins to ensure no overfilling. Staff stored equipment in cupboards was clearly labelled and stored safely.
- Stock cupboards in diagnostic imaging were neat and tidy; all of the stock we checked was in date and safe for use.
- The diagnostic imaging department had a quality assurance programme to ensure regular equipment tests, including output, collimation, and automatic exposure control (AEC). Staff conducted weekly equipment tests in the mammography room between May 2016 and November 2016, with no omissions. Staff also completed monthly checks between April 2016 and November 2016, with no omissions also.

Medicines

- The hospital had its own onsite pharmacist who was available Monday to Friday 9am to 5pm and Saturday mornings dependent on the needs of patients. Staff could seek advice from the resident medical officer (RMO) at any time if they needed further guidance.
- The pharmacy service included ordering medicine and ensuring supplies were available for all areas within the hospital. There was a service level agreement (SLA) in place with a local NHS trust, who supplied the majority of fluids and medicines for the hospital.
- If patients needed medicine urgently, or medicine was not in stock, staff ordered it via phone or email via a local NHS trust to obtain urgent pharmacy orders. A pharmacist was available 24 hours a day, seven days a week, on call via the local NHS trust in the case of urgent medicine supplies needed out of normal hours.
- The hospital staff carried out medication audits routinely, and there was a policy and standard operating procedure (SOP) for medicines management available to staff.
- In the outpatient treatment areas, staff stored medicines appropriately, in locked cabinets and the keys held with the main staff member at all times. Staff completed temperature checks in both the room and refrigerators, we checked the daily records between September 2016 to November 2016, and staff signed and dated these with no omissions.
- Staff stored all medication within diagnostic imaging and contrast appropriately in locked cupboards. Staff stored medication keys in a cabinet with a key code lock, and maintained records of room temperatures daily. We checked room temperature records in the MRI suite and the fluoroscopy room, temperatures were satisfactory and staff carried out daily checks between September 2016 and November 2016.
- Emergency drugs were available within the MRI suite; staff stored these in a tamper proof bag, provided and restocked by the pharmacy staff.

Records

- Information supplied by the hospital prior to our inspection stated that less than 2% of patients attended appointments without medical records being available.

Staff told us that if records were not available they obtained copies of the referrals and medical history for first appointments from the general practitioner (GP) or the referring hospital.

- Staff stored patient records securely within the outpatients and diagnostic imaging departments within locked offices or in areas supervised by staff.
- Records provided by the hospital stated that it was standard hospital practice to keep patient's healthcare records on hospital site. If the hospital transported patient records staff used a locked container within a company vehicle for transportation from and to any external locations. Staff accompanied medical records at all times during any transportation.
- We checked seven NHS funded patient's healthcare records and found patient information misfiled within the patient's records, making it difficult for staff to find key documents relating to patients care, assessment, or treatment.
- Consultants routinely signed notes, but did not write their name for clarity of the signature, nor date the patient record once completed. We found that in five of the seven NHS records we reviewed, there were no consultant notes present.
- During our unannounced inspection we reviewed a further five sets of NHS patient notes, only one had consultant notes present. Staff explained that a number of the consultants used oral dictation to record patient notes; the oral record would then be typed and entered into the patient's record by the administration team within 24 hrs. We were unable to establish if this occurred for all patients since some records had not been written at the time of our inspection, given that those patients had been seen that day.
- We found that in six of the seven NHS patient records we reviewed staff had fully completed the patient health questionnaire. One record was incomplete due to the patient waiting to see a consultant.
- The outpatient service did not carry out audits of records at the time of our inspection, however a manager provided us with a copy of a new audit schedule the hospital planned to implement this in December 2016, which covered key areas of record completion and quality.
- Staff recorded diagnostic imaging details on the radiology department information system (RIS). A radiology information system (RIS) is the core system for the electronic management of imaging departments. Information recorded on the RIS included the examination carried out, the patient identification checked, the radiation exposure, and who carried out the examination.
- The service had direct access to electronic information held by community services, including general practitioners. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicines.

Safeguarding

- The hospital had a central safeguarding register to log all concerns; the matron reviewed this and decided which safeguarding team or external agency to contact. The internal hospital quality improvement team monitored the safeguarding register.
- Between July 2015 and June 2016, the hospital reported no safeguarding concerns in relation to children or adults.
- There were hospital policies and procedures in place for safeguarding adults and children, the hospital reviewed both policies in January 2016, they were up to date with a designated corporate safeguarding lead identified.
- Staff accessed safeguarding training level 1, 2 and 3 via e-Learning. Records showed that 87% of staff compliant with safeguarding level one and two training, which included MCA and DoLS as core modules.
- Records also showed 104 staff (95%) involved in the care of patients aged under 18 years had achieved training in safeguarding children level one and two, and 10 members of staff (9%) were trained to level 3 safeguarding children.
- The hospital had identified that more staff required training to level 3 safeguarding for children and there was an action plan in place to address this. We also saw that training dates planned for most staff.
- Records showed that the registered nurse (children's branch) who worked on a Friday in the outpatient department for children's clinics was up-to-date with level 3 children's safeguarding training.

Good

Outpatients and diagnostic imaging

- The hospital had a flow chart to guide staff through raising a safeguarding concern. We saw this displayed on notice boards across the hospital during our inspection.
- We spoke with four members of staff and all knew how to raise a safeguarding concern and who the hospital safeguarding lead was.
- Staff gave an historic example, that is an incident which occurred over 18 months prior to our inspection, of supporting a patient who had presented at the department and made a disclosure of domestic violence. Staff also gave discussed a case of female genital mutilation (FGM) and a referral to the local children's safeguarding team following a disclosure of possible abuse of children at a local school.
- The hospital had an up-to-date chaperoning policy in place and there were notices throughout the department offering a chaperoning service. Staff told us that they were required to explain the chaperoning procedure to all patients who attend appointments and asked if the patient would like a chaperone in attendance during their appointment. We observed staff offering this service and a patient using the chaperoning service during an x-ray procedure.

Mandatory training

- Four members of staff told us they had recently completed mandatory training via e-Learning and face-to-face training sessions in a variety of subjects, including but not limited to, health and safety, fire, moving and handling, infection control, safeguarding adults and children and basic life support.
- Data supplied by the hospital in relation to outpatient department staff showed an overall 87.5% compliance rate with mandatory training for registered nurses and 87.3% for health care assistants.

Assessing and responding to risk

- We spoke with three members of staff and they were all knowledgeable on how to manage a patient who suddenly became unwell. This included basic observations, contacting the resident medical officer (RMO) and emergency treatment as required.
- Within diagnostic imaging, radiographers trained in both basic life support (BLS) and immediate life support (ILS). Records showed all staff up to date with the necessary life support training according to their job role. Two new members of staff were also booked to attend ILS training.
- The hospital MRI lead explained that they practice the procedure, which they follow if a patient becomes unwell. Due to the specific risks within the MRI suite, there were restrictions on the equipment used in the scanner and staff controlled access to this area. Staff had received training to ensure the safety of the patient as well as the safety of clinical staff that would assist in an emergency. Both the resident medical officer (RMO) and senior nurses received training in safety practices and procedures for the controlled area in the MRI suite.
- Diagnostic imaging staff reviewed previous patient images as well as asking patients if they had undergone a recent x-ray to reduce the risk of patients having unnecessary repeat examinations.
- We reviewed a list of non-medical referrers who were entitled to make a referral request for diagnostic imaging. Staff recorded the referrer name, job title, and signature and the examinations they were entitled to request. There was evidence that the referrer had attended training in Ionising Radiation (Medical Exposure) Regulations (2000) (IR(ME)R). Non-medical referrers included physiotherapists, podiatrists and advanced nurse practitioners.
- The hospital used the "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" for interventional radiological procedures. This reflected evidence-based practice to ensure safety for surgical procedures.
- The hospital had local policies in place for the risk assessment and prevention of contrast induced nephropathy. We viewed the policy and saw that it was up to date and in line with The National Institute for Health and Care Excellence (NICE) acute kidney injury (AKI) guidelines and the Royal College of Radiologists (RCR) standards for intravascular contrast agent administration.
- The diagnostic imaging team checked the pregnancy status of female patients prior to having a diagnostic image examination. This process was in in line with Royal College of Radiographers (RCR) guidelines. Radiographers we spoke with understood the process

and explained its application. Notices were visible in the department advising patients to notify the radiographers if there was a chance they might be pregnant.

Nursing staffing

- Senior ward staff reviewed the acuity of patients via a predicted occupancy tool and allocated staff within the teams based on patient acuity. Managers used an internal hospital IT system to allocate staff and adjust staffing ratios to meet individual patient needs. Health care assistants (HCA) supported the nursing staff. In addition, a premium care assistant who supported the privately funded patients with any additional care and treatment also supported the services.
- The hospital employed a mix of registered nurses (RN), allied health professionals (AHP) and health care assistants (HCA). Data supplied by the hospital showed the outpatients department had 6.3 whole time equivalent (WTE) RN's and 4.8 WTE HCA's, which equated to a ratio of 1.3 nurses to 1 health care assistant. The majority of staff worked on a part-time basis. A manager told us that this gave flexibility in terms of covering the shifts with the right staff skills, at the right appointments.
- On a Friday, the hospital employed a registered nurse (children's branch) to assist all children's outpatient attendances, and therefore children's clinics only ran on a Friday to ensure a children's nurse was present.
- The diagnostic imaging department employed five qualified radiographers and two HCAs.
- Diagnostic imaging used bank staff to cover staff shortfall or during busy times. A manager told us that they used staff from the bank with previous experience of working in the department.
- Between July 2015 and June 2016, the use of bank and agency RNs working in the outpatient department was higher than the average of other independent acute hospitals. This ranged between 16% in July 2015 and 23% in November 2015, and 14% in December 205 to 16% in June 2016; the highest rate of usage was 27% in February 2016.
- Between July 2015 and June 2016, the rate of use of bank and agency HCAs working in the outpatient department was lower than the average of other independent acute hospitals, with the exception of March 2016 and April 2016 when rates were similar to other independent acute hospitals.
- There were no agency nurses or HCA's working in the outpatient department between July 2015 and June 2016.
- The rate of sickness for RNs working in the outpatient department was lower than the average of other independent acute hospitals between July 2015 and June 2016. However, between September 2015 and November 2015, sickness rates were higher than the average across other independent acute hospitals.
- Sickness rates for HCAs working in the outpatients department between July 2015 and June 2016 varied considerably. Data supplied by the hospital showed that in July 2015, August 2015, January 2016, March 2016, and April 2016 the sickness rates for HCAs were higher than the average of other independent acute hospitals ranging between 4% in July 2015 to 10% in March 2016, finally falling to 3% in June 2016.
- The RN vacancy rate within the outpatient department was above the average of the other independent acute hospitals and in July 2016 1.19 WTE posts were vacant giving a vacancy rate of 16%.
- The HCA vacancy rate for the outpatient department was above the average of the other independent acute hospitals and in July 2016 0.7, WTE HCA posts were vacant giving a vacancy rate of 13%.
- Data supplied by the hospital showed there were no unfilled nursing and support staff shifts between April 2016 and June 2016.

Medical staffing

- There were six consultants at the hospital with practicing privileges who performed cosmetic surgery procedures. All were on the General Medical Council (GMC) specialist register.
- The hospital stated that staff turnover data they held was collected hospital wide and that clinical staff data could not be separated from the total staff figures. The hospital wide staff turnover between July 2014 and June 2015 was 19.1% and between July 2015 and June 2016, 25.2%.

Good

Outpatients and diagnostic imaging

- The hospital utilised an external agency to ensure the resident medical officer (RMO) had the appropriate mandatory training including European Paediatric Advanced Life Support (EPALS) and Advanced Life Support (ALS). The hospital matron reviewed the RMO's curriculum vitae including the submission of certificates to show compliance with appropriate training.
- Staff we spoke with knew the RMO on duty, found them to be supportive and available to provide support as and when required. The hospital employed two RMOs who worked on a seven day-shift rota and had accommodation on site to support them taking breaks and getting appropriate rests between shifts.

Emergency awareness and training

- The hospital has a business continuity management policy in place, which was due for review in March 2017.
- We spoke with two members of staff in the outpatient department with regard to emergency planning and disaster recovery. Both staff knew the hospital's business continuity management policy and said that the hospital ran events once or twice a year to simulate an emergency, for example an IT break down.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

- Clinical policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and care pathways, for example, the endoscopy pathway was in line with NICE guidance on preoperative assessments (2003).
- The hospital participated in various audits including the National Patient Reported Outcomes Measures (PROMS), and local hospital based audits for example, infection prevention, protection and control, hand hygiene and medicines management amongst others. We have reported fully on these audits under the surgery core service within this report.
- The hospital conducted quarterly audits of 100 radiologist reports, and a sample of these externally reviewed by a third party. The radiologists received feedback on any discrepancies found. We reviewed an example of a radiologist report that contained a finding, which was not noted on the original report, feedback from the audit included the radiologist's response and action taken.
- The hospital had policies and guidelines for diagnostic imaging department, which included details on 'Local rules', radiation protection supervisor (RPS) and radiation protection advisor (RPA) in line with Ionising Radiation (Medical Exposure) Regulations (2000) (IR(ME)R). RPA support was provided by another NHS trust to the Ramsey group as part of a service level agreement (SLA), staff we spoke with said that the NHS trust were very responsive and accessible for help and advice on RPA.
- The hospital complied with the Royal College of Nursing (RCN) clinical standard for breast care by having a competent band five nurse with a specific interest in breast care as part of the outpatient team, who was available to support patients whilst making or attending an appointment.

Pain relief

- If a patient experienced pain during an appointment, the clinical team assessed the patient and pain relief offered where appropriate.
- The team used the Ramsay pain assessment tool to assess patient pain using a pain scale. If the staff observed any change in the nature of the patient's pain, they initiated a pain review conducted by the prescriber, a registered nurse, or operating department practitioner.

Nutrition and hydration

- Patients had access to water and vending machines for food and drinks, these were accessible on main corridors near to the hospital main reception.
- The hospital did not routinely provide NHS patients hot drinks in waiting areas. Staff would make a hot drink for patients if requested, but staff said this would often cause issues with other patients waiting. Staff we spoke with felt that NHS patients should have access to hot drinks in waiting areas where possible and it was safe to do so.

Good

Outpatients and diagnostic imaging

Patient outcomes

- The hospital conducted an annual audit on radiation dose levels for diagnostic imaging examinations to ensure that radiation doses were in line with national reference levels (NRL). Where local doses exceeded the NRL, staff adjusted equipment or protocol to bring the dose to within acceptable limits.
- Staff would agree to provide a follow up call with patients where necessary following procedures. Initially this would be within twenty-four hours of the procedure, followed by another call within five to seven days, at a time agreed with the patient. This was to ensure the patient was safe and well and to offer any follow on guidance or escalation back to the hospital if the patient had any ongoing health issues.
- Where patients had consented, patients undergoing a joint replacement had their prosthesis registered on the National Joint Registry (NJR). These patients were followed up in outpatient clinic and clinical outcomes recorded.
- The hospital had recruited volunteers to participate in the initial pilot of the International Consortium for Health Outcomes Measurement (ICHOM) to survey patient recorded outcome measures (PROM). We have reported fully on this outcome under the surgery core service within this report.

Competent staff

- Diagnostic imaging staff achieved 100% compliance with their appraisals during the past year. Staff within the outpatient department achieved an 87% compliance rate for the same period.
- The hospital had a local staff induction folder that provided local information on clinical policies and processes for any new staff entering the hospital. All health care assistants (HCA) completed the 'Care Certificate' as part of their induction process. All health care assistants within the outpatient department and radiology had completed the certificate.
- Staff told us that the department was actively seeking ways to increase staff competency and provide opportunities for furthering staff development. The hospital had staff leads for health and safety, breast care and infection control.
- Managers encouraged staff to complete higher-level qualifications to improve performance, and were offered a wide range of qualifications to improve competency, for example a variety of radiology courses, and extended scope practitioner courses. We spoke with one member of staff that was completing a level 5 care related qualification to improve their skills and knowledge as part of a career development programme supported by the hospital.
- One staff member explained they were training as a HCA following their initial employment with the hospital as an administrative assistant. The HCA was extremely complementary of the training and the guidance and support provided by their line manager. Radiographers told us that there were lots of training opportunities and as well as being trained in magnetic resonance imaging (MRI) they had been able to access a number of external courses including a cannulation course run by the Society of Radiographers.
- Revalidation formed part of staff's annual appraisal, for those who required revalidation of professional registration. For consultants, revalidation occurred at the NHS Trust who employed them and via an allocated "Responsible Officer." Fitzwilliam Hospital then reviewed evidence of this process to ensure each consultant had been revalidated with the General Medical Council (GMC).
- The hospital granted consultant 'Practicing Privileges' following processes detailed within the provider's facility rules. The local Medical Advisory Committee (MAC) reviewed all clinical supporting evidence for any new consultant application; final applications were approved by the Ramsay Medical Director in accordance with the Ramsay Corporate Credentialing Committee. Evidence like General Medical Council (GMC) registration, was maintained by all consultants and a structured process of review and evidence gathering managed by the general manager's personal assistant and then recorded on the Ramsay Credentialing Database with all supporting reports.
- Staff told us that their managers were very supportive of their training and development needs, and that they were given time to attend necessary training updates.

Multidisciplinary working

Good

Outpatients and diagnostic imaging

- Radiology staff worked with consultants to develop a list of their preferred protocol for each diagnostic image to create the correct image on the first occasion reducing the need for repeat radiation exposures.
- Staff reported good multidisciplinary working with the ward staff, outpatients, theatres, and physiotherapy.

Seven-day service

- Diagnostic imaging including ultrasound was available Monday to Friday 8am to 8pm and Saturday 8.30am to 4.30am.
- Magnetic resonance imaging was available 8.30am to 7.30pm Monday to Friday and 9am to 5pm on Saturday.
- One stop mammography clinics ran on Monday and Wednesday afternoons
- The hospital had access to out of hours on call x-ray imaging twenty-four hours a day seven day a week.

Access to information

- Staff had access to a wide range of policies and guidance via the hospital intranet; all staff we spoke with complimented this resource and used it frequently. In some areas, for example medication, staff had hard copies of policies in various work areas as a quick reference guide to assist them in their practice. We reviewed a hospital guide for medication and found this to be up to date, comprehensive and of a very high standard.
- Staff had access to computerised diagnostic images and imaging reports via the picture archiving and communication system (PACs). The hospital could transfer diagnostic images taken at other healthcare providers via the image exchange portal (IEP) and make these available to view on PACs.
- Staff accessed the electronic incident reporting tool to review incidents and learning on incident management in order to develop their own practice and share learning with other staff across the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with three members of staff and specifically asked them about their knowledge and understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. All of the staff we spoke with knew the core principles of the MCA and DoLS, and how this would apply in practice.
- One member of staff gave an example of how they supported a patient with dementia and how they had liaised with the patient's family, offering appropriate guidance to gain the patient's consent to treatment.
- We reviewed the hospital policy on consent to treatment for competent adults and children/young people, the hospital reviewed this in June 2016. The policy was comprehensive, in date and compliant with national guidance.
- Consultants were responsible for gaining patient consent for procedures and treatment. We reviewed four consent forms and noted these completed appropriately within patient records.
- Radiography staff gave an example of an instance where a patient had to have a mental capacity assessment to establish consent to an MRI scan. Staff demonstrated that they followed the correct process in line and had a good understanding of the Act.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- The hospital wide Friends and Family Test (FFT) scores were 97.5% between October 2015 and October 2016.
- Staff interaction with patients and visitors was friendly and respectful at all times during our inspection.
- One patient waiting to be seen told us, "The staff here are very kind and helpful, I have had no issues at all with my appointment, and they have been very helpful."
- The hospital patient led assessment of the care environment (PLACE) for 2016, showed that 78% of patient's hospital wide said their dignity and wellbeing was promoted.

Good

Outpatients and diagnostic imaging

- Staff explained the chaperoning procedure to patients when attending appointments and asked if they would like a chaperone in attendance during the patient's appointment. We observed staff and patients using this process when attending for an x-ray procedure.
- Within diagnostic imaging, staff treated patients with respect and dignity. Staff drew curtains in areas where patients were waiting to protect the patient's privacy and staff interacted with patients in a polite and respectful manner. During the inspection, no inspectors accessed any patient areas unless the radiographers checked that the patient was comfortable for us to do so.
- Reception staff greeted patients in a very kind and courteous manner as they arrived for diagnostic imaging and at the various reception areas.

Understanding and involvement of patients and those close to them

- We observed staff supporting a patient to access a treatment room, this member of staff was courteous and took time to explain what was happening and asked if the patient fully understood what was going to happen to them.
- One patient told us that the staff in Magnetic Resonance Imaging (MRI) had explained the procedure very clearly and gave plenty of time to ask any questions.

Emotional support

- We observed a patient having an MRI scan supported by the radiographer to ensure that they were comfortable throughout their examination.
- Staff enabled patients that were anxious about their examination the opportunity to see the scanner prior to their appointment. Staff offered support and answered questions to address any patient concerns in relation to their care or treatment.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital outpatient service was supporting a local NHS services by providing 63% of their service capacity to NHS patients.
- The outpatients department was also developing a partnership with a local service that provided fertility treatments to the public. The service identified that often patients would have to wait extended periods for surgery that may aid fertility, for example, the removal of ovarian polyps. The hospital was working with the service provider to fast track patients for surgery where possible, to reduce waiting times and improve the prospects of fertility.
- The hospital offered free parking and disabled spaces were close to its main entrance to promote access for disabled people.

Access and flow

- Between July 2015 and June 2016, 77, 046 patients attended the outpatient department, of which 1,144 were children from birth to 17 years of age and 75,902 were adults. Of the total attendances, 63% were NHS funded patients, and 37% either self-funded or funded from other sources, for example, private insurance claims.
- The outpatients department exceeded its target of 92% for referral to treatment (RTT) waiting times in less than 18 weeks for the period July 2015 to June 2016 for incomplete patients. These figures related to NHS funded patients only.
- Targets for non-admitted patients' treatment beginning within 18 weeks were abolished in June 2015. It is however positive to note that for the period July 2015 to June 2016, the outpatients department exceeded its 95% target on a consistent basis, reaching 100% in seven months and 99% in the remaining five months.
- The hospital provided data in relation to NHS funded patients and diagnostic waiting times. Between July 2015 and June 2016, no patients waited six weeks or longer from referral for non-obstetric ultrasound, one patient waited six weeks or longer from referral for magnetic resonance imaging (MRI) 2.1% in December 2015 and one patient waited six weeks or longer from referral for computed tomography (CT) 20%, in December 2015.

Good

Outpatients and diagnostic imaging

- We reviewed an incident report relating to a consultant that did not attend for their clinics. Staff had reported this as an incident and we were able to track the issue from initial reporting to conclusion. The consultant claimed his secretary was aware of them not being available for the appointments, but this was not communicated to the hospital. Staff had contacted the patients, offered apologies both verbally and in writing and tried where possible to accommodate patients by moving appointments to suit their needs.
- The outpatients department kept records of waiting times for patients attending appointments and actively sought to identify why delays had occurred and looked at ways of preventing delays of a similar nature occurring in the future.
- A manager explained that patients could choose an appointment to suit their needs, as far as reasonably practicable. Patients could do this via the NHS Chose and Book System or by contacting the hospital directly to make an appointment.
- The diagnostic imaging department provided a walk in x-ray service for patients attending outpatient clinics so that the patient could have their x-ray in conjunction with their appointment avoiding a delay in images for consultant review.
- The hospital offered patients having diagnostic imaging that did not attend their appointment a second appointment before their imaging request was returned to the referrer. Appointment staff attempted to contact patients by phone to make appointments and told us this action had reduced the number of missed appointments.
- Patients could attend evening and weekend appointments to promote access to treatment for patients who have work or family commitments.

Meeting people's individual needs

- The outpatients and diagnostic imaging department had access to translation services for patients whose first language was not English. Staff could use "Language Line," a telephone system where an interpreter supported patients via a telephone, but more often, the team used a face-to-face interpreter service where an interpreter would attend the hospital appointment with the patient to give them direct support. We observed this during inspection where an interpreter was called in specifically to be with a patient so they could understand their care and treatment and ask questions where required.
- The hospital had access to a specialist dementia nurse, who could provide guidance and support to staff in order to meet the needs of patients and their families living with dementia.
- The hospital had access to a specialist learning disability nurse who could provide guidance and support to staff in order to meet the needs of patients with learning disabilities. We reviewed a "Helping me at home" document that had symbols alongside questions to encourage patients with a cognitive impairment or learning disability to express their needs, for example any pain they were feeling or key people involved in their care and support.
- The outpatients department had a couch within a treatment room for bariatric patient use. The team explained how they liaised with consultants and dieticians when supporting bariatric patients in order to provide support and meet their individual needs.
- The hospital patient health questionnaire specifically asked patients questions to identify a patient with any specific needs, for example, special learning needs, dementia, or allergy. This meant that staff could quickly identify specific needs and plan the patient's care and treatment accordingly.
- Strategies were available for patients who may experience claustrophobia whilst inside the MRI scanner. This included listening to music or the radio and giving patients a pair of periscopic glasses to enable the patient to see outside of the MRI scanner whilst undergoing a scan to reduce the feeling of claustrophobia.

Learning from complaints and concerns

- The outpatient department had five complaints between January 2016 and October 2016. These related to a cancelled procedure; a consultant's attitude and behaviour; a clinical procedure; a consultant not attending their clinic who kept their patient waiting and regarding a patient's blood test having to be repeated due to initial results going missing.

Good

Outpatients and diagnostic imaging

- There were no complaints reported to the Care Quality Commission in relation to the hospital between July 2015 and June 2016.
- The hospital had a policy titled "Management of Patient Complaints" to guide staff on how to respond to complaints. The hospital general manager and matron reviewed complaints initially. The quality improvement team then reviewed the complaint and the relevant clinician or department provided statements to support the complaints investigation. The appropriate head of department investigated the complaint and their findings sent to the quality improvement team to draft a complaint response.
- All complaints were logged formally on an IT based reporting system and actions tracked via a local action log. The quality team recorded evidence of compliance with complaints on the system to give assurance that actions were completed and lessons learned. In addition, staff logged all compliments using this system.
- Staff discussed complaints at team meetings and had the opportunity to reflect on what went wrong in order to prevent repeated issues in the future. The hospital senior management team discussed the complaints activity at their weekly meetings and records provided by the hospital demonstrated this.
- Staff told us that they got positive feedback from patients and that this was often celebrated and recognised in an email from their line manager or other senior staff in the hospital.
- Patients could access "We Value Your Opinion," a questionnaire completed by patients whilst in hospital to comment on the quality of the food, hygiene, cleanliness, the care provided and the environment. The questionnaire had a free text section for patients to add any further comments they deemed relevant to their stay.

Are outpatients and diagnostic imaging services well-led?

Good

Vision and strategy for this this core service

- There was no local strategy or vision for the outpatients or diagnostic imaging departments. The service worked to the corporate 'Ramsay Way' which was an overarching strategy. The staff we spoke with during our inspection knew the hospitals' wider vision and strategic aims.

Governance, risk management, and quality measurement

- The hospital had a clear governance structure in place with committees such as clinical governance, senior management, and heads of department feeding into the medical advisory committee (MAC) and hospital management team.
- Clinical heads of department attended the clinical governance committee and cascaded information to their team members. Governance information was displayed on governance information boards across the hospital. A quality improvement facilitator updated the governance boards monthly. Information on the boards included information on the prior month's complaints, incidents, trends, actions, audits, infections, satisfaction results, training statistics, and any relevant policy changes.
- Staff we spoke with knew the risks identified on the hospital risk register that specifically related to the outpatients department. The identified risks were in relation to scope decontamination and risk assessments for sharps. The risk register identified the risks and actions taken to mitigate these as well as the person dealing with the risk and timescales involved.
- Departmental team meeting minutes showed managers discussed departmental risks with staff. Two members of staff shared an example of a risk identified in a treatment room due to excessive heat in periods of hot weather. The staff explained how this affected patients, staff, and the storage of medication. The hospital subsequently installed air conditioning in the treatment rooms, which enabled staff to control and monitor the temperature of the room to maintain the safety of medication and promote patient and staff wellbeing.
- Whilst the outpatient staff were aware of risks, risk management and what it constituted, the overall risk

register for the hospital had not identified the availability or recording of outpatient records as a risk within the service. The service was not aware of the risks identified during the inspection.

Leadership and culture of service

- The outpatients department had a dedicated manager, who reported to the hospital matron. The department did not have a deputy manager, instead the manager offered opportunities to the team to develop their skills and take responsibility for various areas of practice, for example, health and safety and risk management. There was also dedicated radiology manager.
- All staff we spoke with thought highly of their managers. They told us that managers promoted a good team culture that they created a lovely place to work, they worked tirelessly to make the department an effective and safe place for patients, visitors and staff, and they went that extra mile to recognise staff's good performance.
- Staff said they felt able to raise issues or concerns without fear of retribution and that the culture was professional, patient focused and staff centred to ensure that they had what they needed to do their jobs to the best of their ability.
- Senior hospital managers were visible within the department however; we received mix feedback from the staff team on their performance and approachability. Some staff felt the senior team were not approachable and that they were impersonal and only focused on hospital results and often unaware of the impact of their behaviour. Other staff felt that senior managers were approachable and helpful when they needed support.
- Meeting records showed that the team discussed issues relevant to the safe management and effective leadership of the department, including staffing levels, absence management, patient needs, and shift patterns.

Public and staff engagement

- The hospital obtained patient feedback via a number of feedback mechanisms including the NHS Friends & Family Test and the "We Value Your Opinion" questionnaire. The hospital reviewed the results monthly, comments were shared and reviewed at the clinical governance meeting, the scores and participation rates were discussed at the quarterly quality review meetings with the relevant commissioning groups.
- Following discharge from hospital, patients could participate in a telephone questionnaire conducted by a third party, to ask about their hospital experience. The results of the questionnaire were shared with the hospital, and patients were contacted via letter and thanked for their feedback. The quality improvement and senior management team then identified any improvements that could be made to the services following a review of the information provided by patients.
- The hospital also reviewed the "NHS choices" feedback on a regular basis and a response provided to all comments.
- The hospital utilised Facebook and Twitter and regularly reviewed these social media accounts and responded to all comments.
- A patient and public involvement group met bi-annually and actively took part in the annual NHS Patient Led Assessment of the Care Environment (PLACE) audit.
- The hospital carried out staff surveys and the results from these were shared in an open staff forum. Staff had the opportunity to meet with a manager at the forum and provided their own agenda items for discussion and debate. Actions from these forums were fed back to the employee engagement group and the hospital acted to make improvements based on staff feedback where possible.

Innovation, improvement, and sustainability

- The service had a system in place whereby each referring consultant had indicated his or her preferred contact method should a significant unexpected finding be seen on a patient's diagnostic image. This meant that the patient could be seen earlier than their pre-planned appointment should the patient require further imaging or treatment.
- The hospital had recruited volunteers to participate in the initial pilot of the International Consortium for Health Outcomes Measurement (ICHOM) to survey patient recorded outcome measures (PROM).

Outstanding practice and areas for improvement

Outstanding practice

- The service had direct access to electronic information held by community services, including general practitioners. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The outpatients department was developing a partnership with a local service that provided fertility treatments to the public.The service identified that often patients would have to wait extended periods for surgery that may aid fertility, for example, the removal of ovarian polyps. The hospital was working with the other service provider to fast track patients for surgery where possible, to reduce waiting times and improve the prospects of fertility.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that services and provision for children and young people are effectively, monitored, risk assessed and managed.
- The provider must ensure that records of outpatient consultations are recorded and filed in patient records, and also that these records are available.

Action the provider SHOULD take to improve

- The provider should ensure that records are accurately completed.
- The provider should ensure that consultants sign and date all patient records, and the name of the staff signing the record is legible.
- The provider should ensure that training compliance with mandatory and safeguarding training improves.
- The provider should ensure that there are systems to ensure that records of care and treatment are available and can be accessed when required for private patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that systems related to children and young people were effectively monitored, assessed or measured for patient outcomes. The provider had not ensured that a complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided was available for all patients. Regulation 17 (1)(2)(a) and (c)