The Berkshire Independent Hospital

Quality Report

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

Ratings

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

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

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

Summary of findings

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

The Berkshire Independent Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 43 inpatient and day-case beds. Facilities included three operating theatres, a two-bed level two care unit, and outpatient, x-ray and diagnostic facilities.

The Berkshire Independent Hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected services for surgery, medicine and outpatients / diagnostic imaging. The hospital had provided services for children and young people; however this service had been suspended pending review. The service was small and there was insufficient evidence to rate.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 5 and 6 December 2016.

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

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

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

Services we rate

We rated this hospital as good overall.

The senior management team, supported by the Heads of Departments, had a clear knowledge of how services were being provided and were quick to address any risks that were identified. They accepted the responsibility and ownership of the quality of care and treatment within the hospital and staff had a similar sense of pride in the hospital.

Care delivered was planned and delivered in a way that promoted safety and ensured that peoples' individual needs were met. We saw patients had their individual risks identified, monitored and managed and that the quality of service was regularly monitored.

The general manager was in charge of the hospital, and all employed staff were line managed by the senior management team; matron, finance manager and operations manager. There were three senior managers that reported directly to the general manager: these were the operations manager, matron and finance manager. Heads of clinical departments reported to matron, including pharmacy manager, outpatients, diagnostic imaging and physiotherapy manager, ward manager, theatre manager and endoscopy manager.

The Medical Advisory Committee (MAC) met four times a year and included representation from all specialities offered at the hospital. It was attended by the general manager and the matron. Issues were discussed and action taken in response to any concerns or risks reported. Minutes of MAC meetings were distributed to all consultants at the hospital.

There were robust governance systems that were understood by staff, these were used to monitor the service and drive service improvement. We did not identify any concerns that the senior management team or local managers were not already aware of and already addressing.

Summary of findings

We saw a strong safety culture with policies and systems in place to allow staff to challenge practice where they identified risk or potential harm. There was an admission criteria, pre-assessment processes and consultants could only carry out procedures that they were undertaking frequently in the NHS. This ensured that the hospital was able to meet the patients' needs safely.

There was a positive culture among staff, many of whom had worked at the hospital for many years. These experienced staff offered stability and continuity to the benefit of newly appointed staff, which brought a fresh energy and encouraged development and new ways of working. The consultants with practising privileges held substantive jobs at the local NHS trusts and were used to working collaboratively.

We found good communication locally and from Ramsey corporate division, with updates provided to staff to ensure practice was in line with NICE guidance and risks were identified from medicines and medical device alerts.

We found good practice in relation to outpatient care:

- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and meet their needs.
- Staff ensured patients were given sufficient information in a way they could understand. Patients were involved as partners in care and their decisions were respected.
- There was a good understanding amongst staff at all levels about safeguarding arrangements and the Mental Capacity Act 2005.
- Patients were seen in a timely manner. Appointments were offered at times that suited patients. Consultations and treatment were provided within the target referral to treatment times. Patients were seen promptly and delays were not common.

We found areas of good practice in surgery:

- In surgery, staff worked hard to make the patient experience as pleasant as possible. Staff recognised and responded to the needs of patients from referral before admission to checks on their wellbeing after discharge.
- The theatre team provided a safe surgical environment by insisting that all theatre users adhered to national and local theatre best practice guidance. The WHO Five Steps to Safer Surgery checks were used routinely, with all staff present and participating fully.
- Incident reporting was encouraged and staff were supported to raise concerns. There was an embedded culture of learning from incidents that spread across the whole hospital.
- There were robust governance arrangements for surgical services at the hospital.Any anomalies in practice, trends in incidents or complaints were picked up and addressed swiftly. Lessons learned were disseminated across the organisation.
- There were appropriate transfer arrangements in the event of a sudden and unexpected deterioration of a patient. Deteriorating patients were identified and transferred to a local NHS hospital in a timely manner; there was good communication with the receiving hospital.
- Patients were positive about the level of care they received from all staff from the beginning of their contact with the hospital to the end.

We found areas of good practice in medicine:

- Patients were very positive about their experiences at the hospital. They felt supported and involved in their care and treatment.

Summary of findings

- The arrangements for medicines management were good with multidisciplinary input from the pharmacy team.
- Areas we visited were clean, tidy and fit for purpose. The environment was pleasant and comfortable. Audit results demonstrated that infection prevention and control measures such as hand hygiene and cleaning were fully implemented.
- The use of the NEWS system for identifying patients at risk of deterioration was embedded and used correctly. Staff followed the hospital's escalation processes and transfer policy.

Professor Edward Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. There were a small number of medical patients that used the service at The Berkshire Independent Hospital. There was an infusion service that treated a small number of regular patients each month on a day case basis. We have also reported endoscopy services under medicine. We rated this service as good because; • Areas we visited were clean, tidy and fit for purpose. The environment was pleasant and comfortable for patients. • There was an embedded culture of incident reporting. Investigations were robust and there was evidence that learning was shared both within the hospital and across the organisation. • The endoscopy suite had Joint Advisory Group (JAG) accreditation incorporating the endoscopy global rating scale, which is a quality improvement and assessment tool for endoscopy services. • Medical services had an appropriate level of competent staff. The RMO was well supported by consultant physicians. • Patient feedback about the quality of care was consistently good. • Managers were visible, approachable and effective. • Referral to treatment targets were consistently met with patients being given appointments and receiving treatment in a timely way.
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. Staffing for surgery was managed jointly with medical care. We rated surgery as good because;

Summary of findings

- Patients received safe, effective and appropriate care, treatment and support that met their individual needs and protected their rights.
- The care delivered was planned and delivered in a way that promoted safety and ensured that people's individual needs were met. We saw patients had individual risks identified, monitored and managed, and that the quality of service was regularly monitored.
- The clinical environments we visited and other communal areas in the hospital were clean and fit for purpose. Hospital-acquired infections were monitored and reported rates were of an acceptable range for the size of hospital.
- Outcomes for patients were good, and the department followed relevant national guidelines.
- Complaints were investigated and handled in line with a standard policy. We saw the hospital used patient complaints and feedback for service improvement. The hospital encouraged feedback from its patients and their relatives.
- We saw that the World Health Organisation (WHO) five steps to safer surgery checklist was used correctly and its use was embedded in practice.
- Surgical equipment was available and working correctly in theatres.
- The theatres were well managed and managers had the trust and support of their staff, and also had good working relationships with senior staff at the hospital.
- The morning huddle meeting was an effective way to plan for the day ahead and learn from the previous day's events.
- Staffing levels in theatres were appropriate.
- There was an open culture for reporting and learning from incidents.
- The hospital had clear policies and protocols for cleaning and infection prevention and control that staff adhered to.
- Patients were positive about the care they received from all hospital staff.

However,

Summary of findings

- Although staff were given time to complete their mandatory training, compliance with this was below the hospitals' target.

Outpatients and diagnostic imaging

Good

Outpatient and diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated outpatients and diagnostic imaging as good because:

- The hospital had systems and processes in place to protect patients from harm.
- Infection prevention and control practices were good, and staff followed hospital policies.
- The care environment was visibly clean, well presented and fit for purpose.
- Medicines were managed and stored correctly; administration was in line with good practice and relevant legislation.
- Patient care records were accurate and stored securely in line with the Data Protection Act 1998.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- The outpatient and diagnostic imaging services had sufficient numbers of appropriately trained competent staff to provide a safe service.
- We observed that staff interactions with patients were kind, caring, and considerate and respected their dignity. Patients told us they were put at ease when having their investigation.
- The hospital was responsive to the needs of the population it served. Appointments could be accessed in a timely manner and at a variety of times throughout the day.
- Managers were visible, approachable and effective.

Summary of findings

Contents

Good

The Berkshire Independent Hospital

Services we looked at
Medical care; Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to The Berkshire Independent Hospital

The Berkshire Independent Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1993 and is a private hospital in Reading, Berkshire. On-site facilities include outpatients' services, a diagnostic imaging department, inpatient facilities, an endoscopy unit, theatres and a sterilisation unit. It provided a service to people in Reading and Berkshire.

The hospital has been previously inspected by CQC four times. The most recent inspection took place in March 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

The hospital has had a registered manager in post since January 2015.

Our inspection team

Our inspection team was led by: a CQC inspector supported by; two CQC inspectors and an inspection manager. Five specialist advisors including a children's nurse, surgeon, surgical nurse, radiology manager and a governance lead.

Why we carried out this inspection

We carried out this inspection as part of the schedule of comprehensive inspections of independent acute hospitals.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information that we held about the hospital. We carried out an announced inspection visit between 5 and 6 December 2016.

We spoke with staff and managers individually. We spoke with patients, relatives and staff from the ward, operating department, endoscopy unit, imaging and outpatient services. We observed care and treatment, and reviewed patients' records.

Information about The Berkshire Independent Hospital

The hospital has 43 beds accommodating inpatient day case patients.

It is registered to provide the following regulated activities:

- Diagnostic and screening procedures

Summary of this inspection

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

During the inspection, we visited a surgical and day case wards, the diagnostic imaging, outpatient and physiotherapy units, as well as the operating theatre suite and sterile supply unit. We spoke with 37 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with nine patients and three relatives. We also received 35 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 13 sets of patient records.

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12 months before this inspection.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 4,796 inpatient and day case episodes of care recorded at the hospital; of these 55% were NHS-funded and 45% privately funded.
- 47% of all NHS-funded patients and 22% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 22,349 outpatient total attendances in the reporting period; of these 51% were NHS-funded.

86 qualified consultants have practising privileges and lead the medical and surgical services.

Track record on safety:

- 0 never events
- Clinical incidents 125 no harm, 24 low harm, 9 moderate harm, 1 severe harm, 0 death
- 15 non-clinical incidents
- 1 serious injury
- 0 incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) or Meticillin-sensitive staphylococcus aureus (MSSA)
- 0 incidences of hospital acquired Clostridium difficile (c.diff) or E-Coli
- 43 complaints

Services accredited by a national body:

- Endoscopy service has Joint Advisory Group (JAG) accreditation

Services provided at the hospital under service level agreement:

- Blood transfusion service
- Computerised tomography scans
- Registered Medical Officers

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The hospital had an open culture and incidents and near misses were reported. There was evidence that incidents were investigated and learning from them was shared.
- There was an embedded safety culture across the hospital.
- Although staff were given time to complete their mandatory training, compliance with this was below the hospitals' target.
- Sufficient staff had undergone training in adult and children's safeguarding.There were designated leads for safeguarding.Staff knew what to do if they had a safeguarding concern.
- The hospital was clean, and staff adhered to policies to prevent the spread of infection. Standards were subject to check through an audit process.
- In the diagnostic imaging department there were appropriate recorded safety checks of equipment in line with legislation. Radiation incidents were reported. There was sufficient equipment across the wards and theatre to provide safe treatment, this included equipment for resuscitation that was checked daily.
- Medicines were managed correctly and securely across all departments. The pharmacy department worked with other departments to ensure the safety of medicines.
- Patients' records were maintained securely, but were available to staff that needed to use them.
- There were appropriate risk assessments carried out for patients admitted to the hospital. There were robust processes for the escalation of a deteriorating patient and a policy to transfer out to NHS care if required.
- There were sufficient numbers of suitably qualified nursing staff to support patients. There was a registered medical officer at the hospital across 24 hours.

Are services effective?

Good

We rated effective as good because:

- Care and treatment was provided in line with legislation and evidence based guidance.
- Surgical patients were given nutrition and hydration in line with best practice. Patients were not starved for prolonged periods without intervention.

Summary of this inspection

- Patients were given pain relief if they required it. The effectiveness of pain relief was checked and escalated if insufficient. Staff asked and recorded pain scores.
- Patient outcomes were recorded and were good. The service was benchmarked against other hospitals.
- Staff had appropriate skills, experience and training to deliver safe care and treatment.
- Departments and different clinical roles across the hospital worked together to provide a patient centred service.
- Staff had access to information they needed to provide safe and effective care.
- Staff were aware of the impact of the Mental Capacity Act 2005, especially in regard to gaining consent to treatment from adults and children.

Are services caring?

Good

We rated caring as good because:

- Patients reported that they felt safe and well cared for.
- Staff treated patients with dignity, respect and compassion across all services.
- Patients were supported emotionally with their care and treatment.
- Patients were involved in all decisions about their care and treatment and were involved as partners.

Are services responsive?

Good

We rated responsive as good because:

- Services were organised to meet the needs of the population that the hospital served.
- Information could be given to patients in a way they could understand.
- The individual needs of patients were assessed and care plans devised that reflected their preferences.
- Patients could access services in a timely way. Appointments were available at times that suited them. If patients needed to return to the hospital after a complication this would be swiftly arranged.
- There was a robust complaints process. Complaints were investigated and patients given appropriate communication. Learning from patient complaints was shared across the hospital through a variety of means.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- The hospital had a set of values and statement of vision that was alive for the staff. Delivering a quality service that would be recommended was important to the staff.
- There was a robust governance structure at the hospital, where incidents, complaints and risk were discussed, monitored and mitigated.
- There was a programme of audit and measures in place to test the quality of services across the hospital.
- The hospital leadership team were visible and accessible to staff and supported an open culture of quality and improvement. Staff were involved in developments within the hospital and felt they could contribute to the hospital's vision.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Medical care

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

Information about the service

Medical service provided by this hospital consisted mainly of endoscopic procedures to insured, NHS funded and self-paying patients. The hospital also accepted a small number of patients for medical infusions. The infusion patients numbered approximately one or two per month and were cared for and treated on the wards under the care of the surgical nurses.

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

Summary of findings

Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

There were a small number of medical patients that used the service at The Berkshire Independent Hospital. There was an infusion service that treated a small number of regular patients each month on a day case basis.

We have also reported endoscopy services under medicine.

We rated this service as good because;

- Areas we visited were clean, tidy and fit for purpose. The environment was pleasant and comfortable for patients.
- There was an embedded culture of incident reporting. Investigations were robust and there was evidence that learning was shared both within the hospital and across the organisation.
- The endoscopy suite had Joint Advisory Group (JAG) accreditation incorporating the endoscopy global rating scale, which is a quality improvement and assessment tool for the endoscopy service.
- Medical services had an appropriate level of competent staff. The RMO was well supported by consultant physicians.
- Patient feedback about the quality of care was consistently good.
- Managers were visible, approachable and effective.

Good

Medical care

- Referral to treatment targets were consistently met with patients being given appointments and receiving treatment in a timely way.

Are medical care services safe?

Good

We rated safe as good.

Incidents

- See information under this sub-heading in the surgery section.
- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the hospitals electronic reporting system and to learn from them. For example, we were told of a reported incident where an endoscope was hung incorrectly in a washer meaning it was not able to be used. This resulted in a change to standard operating procedures and additional training for endoscopy staff.
- Staff we spoke with were able to describe the process of incident reporting and understood their responsibilities. There were no specific themes relating to the medical service, however minutes from clinical governance meetings demonstrated that incidents was a standard agenda item. Representatives from theatres and wards attended these meetings and staff told us they received information regarding these meetings.
- There were no never events and no deaths reported during the period July 2015 to June 2016.

Clinical Quality Dashboard or equivalent

- See information under this sub-heading in the surgery section.

Cleanliness, infection control and hygiene

- Please see core service report for surgery for main details regarding the wards.
- The hospital had infection prevention and control (June 2014) and hand hygiene (March 2015) policies. Staff had access to these policies via the hospital intranet.
- We observed staff in the endoscopy unit and on the wards wearing uniforms with short sleeves and they adhered to the bare below the elbow policy.

- Staff wore gloves and aprons appropriately when providing care to patients. Staff also washed their hands before and after providing treatment to patients. We observed them using sanitising hand gel appropriately.
- The hospital had decontamination facilities onsite, the Theatre Sterile Supply Unit (TSSU) for managing sterilisation services and supplies. TSSU were responsible for the decontamination of the endoscopes and reusable surgical equipment for the hospital only.
- We observed the flow of clean and dirty endoscopes during a procedure. The process was robust and carried out effectively by trained TSSU staff.

Environment and equipment

- Please see core service report for surgery for main details regarding the wards.
- The endoscopy suite was self-contained and located away from the main theatres. There was a consulting room, private changing facilities for patients with lockers, an accessible toilet, a first stage recovery room with three beds, a second stage recovery room with reclining chairs, a decontamination room (separate clean and dirty rooms) and a procedure room.
- The hallways throughout the endoscopy suite were carpeted, and although staff told us the carpets were cleaned they were unsure of the level and frequency of the cleaning schedule.
- Nurses told us that they cleaned the procedure and recovery rooms after the completion of each endoscopy list. We were told a deep clean of the procedure and recovery rooms took place weekly, however we did not see any cleaning schedule to confirm this.
- The endoscopy procedure room was spacious, well organised and contained only the equipment needed.
- The endoscope decontamination room was compact but well organised. Washers were in good order and TSSU staff carried out daily checks to ensure they were working correctly.
- Comprehensive and detailed records were maintained of these checks, which were signed off by TSSU staff. TSSU staff reported that contractors were responsive to requests should there be a technical issue with the washers.
- Resuscitation equipment in endoscopy was available. The resuscitation trolley was sealed with a tamperproof tag with a unique identification number which was recorded in the records. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff and was safe and ready for use in an emergency.

Medicines

- There was a medicines management policy, dated November 2014, that staff used to guide their practice. Staff also had access to the British National Formulary for guidance on medicines.
- Anaphylaxis kits, for treating a severe allergic reaction to medicines or treatment, were accessible, in-date and clearly marked in the endoscopy department.
- Medicines were stored in locked cupboards. Medicines that required temperature controlled storage were stored in a locked refrigerator. We saw that minimum and maximum temperatures had been checked, by the pharmacist, and recorded appropriately. Staff we spoke with could describe the actions to take if temperatures were not within range, and there was guidance on the record sheets.
- A patient having an endoscopy could choose to have the procedure carried out under sedation. Endoscopy staff ensured medicines were available in case a patient had an adverse reaction to sedation.

Records

- The hospital had policies in place for clinical record keeping (dated March 2017) and the security of medical records (dated January 2018). A Confidentiality clause is signed by all staff, and patient records were only handled by Ramsay staff. There was a standard operating procedure in place for transfer of medical records, and records were not routinely removed from the site.
- We reviewed two sets of patient records and saw that staff kept accurate, legible and contemporaneous records. We saw evidence of endoscope traceability, procedure details, patient consent and the treatment report.

Safeguarding

Good

Medical care

- There was a safeguarding adults at risk of abuse or neglect policy, dated November 2014, and a safeguarding children and young person's policy, dated March 2016, that staff used to guide their practice.
- Quality Improvement Manager was the local children's safeguarding lead. There was also a Ramsay corporate lead available for advice as required. The local safeguarding lead provided Safeguarding Level 3 training at the Hospital, following completion of NSPCC Accredited Course.
  Staff received mandatory training in the safeguarding of vulnerable adults and children level 1 as part of their induction, followed by refresher training. In July 2016, the rate for Level 1 safeguarding children and young adults training was 90% and for safeguarding vulnerable adults level 2 was 93%, against the hospital's target of 100%.
- There were no safeguarding concerns reported to the CQC in the reporting period July 2015 to June 2016. Staff we spoke with could describe their roles and responsibilities in reporting and taking action when safeguarding issues were identified.

Mandatory training

- See information under this sub-heading in the surgery section.
- Staff completed a number of mandatory training modules as part of their induction. The mandatory training programme included modules such as fire training, basic life support, manual handling, blood transfusion, infection control, hand hygiene, PREVENT, children (level1) and adults (level 2) safeguarding, deprivation of liberty and Mental Capacity Act.
- Staff had access to a range of electronic and face-to-face mandatory training. Mandatory e-Learning sessions could be accessed on the corporate intranet.
- Staff were supported to complete this training and time was given to staff to enable them to complete any required learning. Most staff we spoke told us they had completed their mandatory training, or were working towards completion, and there were no problems accessing eLearning or mandatory training modules.

Assessing and responding to patient risk

- The medical and nursing staff in endoscopy completed a 'five steps to safer surgery' (WHO) checklist in endoscopy. This is an internationally recognised system of checks before, during, and after surgery, are designed to prevent avoidable harm and mistakes during procedures. We observed staff using the checklist correctly during our visit.
- The national early warning system (NEWS) is a scoring system that identifies patients at risk of deterioration, or needing prompt medical review. This included physical observations of patients to detect signs of deterioration. This system was used for endoscopy patients admitted to the medical service. Medical and nursing staff were aware of the appropriate escalation action to take if a score indicated a patient had deteriorated.
- The hospital reported no deaths and did not have any end of life patients in the reporting period July 2015 to June 2016.

Nursing staffing

- The lead nurse in the endoscopy department confirmed the skill mix and competencies of staff. This enabled the needs of patients attending the department to be met effectively. Staff had the appropriate competencies or were working towards attaining them; we saw training records that confirmed this.
- Nurse training records for endoscopy were in excellent order, fully indexed and included all departmental standard operating procedures and competencies.
- All endoscopy nurses had read and signed an 'Endoscopy Etiquette' statement which detailed expectations for staff while working in the endoscopy unit. This was kept on the front of each individual staffs training file.

Medical staffing

- The medical staffing arrangements are reported under the surgery service within this report.

Emergency awareness and training

- Please see core service report for surgery for main details.

Are medical care services effective?

Good

Medical care

Good

We rated effective as good.

Evidence-based care and treatment

- See information under this sub-heading in the surgery section.
- Policies and guidelines were developed in-line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example, the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50.
- The hospital had joint advisory group (JAG) accreditation for endoscopy services. This was awarded in June 2014 and was the only accredited private provider in the local area.
- There was an on-going audit programme to monitor care and review clinical practice. The provider participated in the corporate national audit programme, which required hospital teams to audit different aspects of care provision on a monthly basis. We saw evidence this programme was adhered to and audit findings were presented at governance meetings. Recommendations for improvement were identified and actions were put in place. We saw minutes of meetings that confirmed this.
- The hospital told us that they benchmark their services against other Ramsay sites. The national clinical governance committee reviewed all key performance indicators.
- The hospital used a number of different care pathways depending on the type of treatment a patient was having, to ensure staff followed a set care pathway that met the needs of each patient.

Pain relief

- Nurses in endoscopy monitored a patient's pain using a numerical pain scale. We observed, and patients told us, that staff closely monitored their pain level during their procedure and provided appropriate support. The two medical records we reviewed in endoscopy reflected that staff completed regular pain assessments and patient received consultant prescribed pain relief.
- Endoscopy patients were offered a throat spray to reduce discomfort and / or intravenous sedation, to minimise any discomfort or pain whilst undergoing a gastrointestinal endoscopy. Medical staff also performed gastrointestinal endoscopies under a general anaesthetic where this was clinically indicated. This procedure would be undertaken in theatre if required.
- Colonoscopies were performed under intravenous sedation, to ensure a person was relaxed and comfortable during the procedure.

Nutrition and hydration

- The hospital advised patients undergoing an endoscopy could have clear fluids up to two hours before their admission time. The staff explained how they would liaise with the anaesthetist if there were any delay to the endoscopy list, to ensure patients were not without fluids for several hours.
- Patients undergoing an intestinal endoscopy, were given detailed advice on how to prepare for the procedure, including advice regarding dietary and fluid intake.
- Medical patients were primarily day patients only. Staff offered patients drinks and snacks as appropriate to ensure they were comfortable during and after their treatment.

Patient outcomes

- See information under this sub-heading in the surgery section.
- The endoscopy service provided at the hospital was accredited by the Joint Advisory Group on GI Endoscopy (JAG). JAG accreditation indicates that the service provides endoscopy in line with the Global Rating Scale Standards.
- The hospital participated on Ramsay corporate steering groups for decontamination.

Competent staff

- Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in an independent hospital following

approval from the medical advisory committee (MAC). This included the hospital making checks such as disclosure and barring service (DBS) checks, qualifications and experience to practise.

- Medical staff performed endoscopy procedures and were supported by nurses with specific endoscopy skills. Staff working in endoscopy were trained and were competent in clinical aspects of endoscopy.This included supporting a patient through a procedure, management of specimens and the decontamination of endoscopes.
- Nurses in the endoscopy department were assessed against specific competencies for their role. We saw training records which showed staff had undertaken training relevant to their role and these were signed off by the lead nurse endoscopy.
- Staff in the TSSU had specific endoscope decontamination training, including training provided by the company that supplies the washers.We saw details of this recording in training records.

Multidisciplinary working

- There was a daily 'huddle' meeting where representatives from all departments meet to share immediate updates of activity, staffing, incidents and social news. This had enabled departments to develop better engagement and understanding of their individual issues.This has also offered opportunities for staff to work across departments but within their scope of practice.
- During our inspection, we saw the administrative, pre-assessment, endoscopy and medical and nursing staff worked well together to ensure the patient pathways were effective.

Access to information

- There was a medical records management policy, dated January 2015, and a clinical recording keeping policy, dated November 2014, that staff used to guide their practice.
- Staff were able to access information on the hospital intranet, which included clinical policies and standard operating procedures. There was also patient information such as; information leaflets to support a patient giving informed consent. Staff could print these from the intranet to give to patients when required.
- Nursing and medical staff did not have any concerns about access to patient records, they told us they were available when a patient attended for treatment or care.
- Discharge summaries were sent to GPs when patients were discharged, staff recorded this had been completed in the patient pathway document. Care and discharge summaries were also given to patients on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- There was a corporate wide consent policy and a deprivation of liberty safeguards policy in place. The consent policy set out clear guidance for staff to follow when taking consent, including what steps to take if there was reason to doubt an adult's capacity to consent and taking consent from patients who did not speak English as their first language.
- Training records for the hospital showed 57% of clinical and 70% of non-clinical staff had undertaken the mental capacity and deprivation of liberty safeguards training.
- Where patients lacked capacity to make their own decisions, staff told us that they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff we spoke with understood the principles of consent and the Mental Capacity Act. Staff told us that it was a consultant-led service and if a patient lacked capacity to provide consent for any procedure they would escalate it to the responsible consultant and not continue with the treatment. The consultant would carry out a mental capacity assessment.
- Patients received information prior to an endoscopy procedure. This allowed patients to review the

information and, if understood, give consent when they came for their procedure. Consent forms we reviewed were appropriately completed signed and detailed the risks and benefits of the procedure.

Are medical care services caring?

Good

We rated caring as good.

Compassionate care

- We spoke to two patients whilst on inspection and they told us they were treated with dignity and respect at each stage of their stay in the hospital. They told us that staff spent time with them and put them at ease.
- Patients told us they were happy with the quality of care and treatment they had received. They told us that staff had made them feel relaxed and comfortable prior to having their procedure.
- We observed that staff were attentive to patients while they were in the endoscopy recovery rooms and requests for assistance were answered in a timely manner.
- We observed staff took care to ensure patients' dignity was preserved. For example, staff ensured patients were covered in the endoscopy procedure room and during transfers to the recovery room.
- We saw people treated as individuals, and staff spoke to patients in a kind and sensitive manner. We observed that staff were friendly, polite respectful and courteous.
- In the Patient-Led Assessments of the Care Environment (PLACE) privacy, dignity and well-being scored 86%, above the England average of 83% for the period February 2016 to June 2016.
- The hospital's Friends and Family Test (FFT) scores were 98-100%, these were similar to the England average of NHS patients in the period February 2016 to June 2016. Response rates were below the England average of NHS patients across the same period.
- Patient feedback was reviewed monthly and scores and comments shared and reviewed at the clinical governance meeting and shared with relevant clinical commissioning groups.

Understanding and involvement of patients and those close to them

- Ramsay undertook a quarterly survey that asked patients if they got answers from nurses they could understand, the right amount of information about condition, care and treatment given, overall experience and likelihood to recommend.
- Information was given to patients about their procedure at their pre-admission appointments. All of the patients we spoke with told us they felt they had been given sufficient information before attending the hospital to prepare them for the procedure and afterwards.
- Patients told us all staff had given clear explanations, in sufficient detail for each stage of their care and treatment, from initial consultation through to discharge.
- Patients in endoscopy told us they understood their care and treatment and had adequate opportunities to discuss the procedure. Patients said, "Staff explained everything that was going to happen at each stage".

Emotional support

- Patients were positive about the emotional support they received from staff especially around anxiety pre and post-procedure. We saw that staff were empathetic towards patients and spent time alleviating patients concerns and anxieties.
- Sufficient time was allocated for the pre-assessment appointment to allow patients time to discuss any fears or anxieties.
- Staff in endoscopy demonstrated sensitivity towards the emotional needs of patients and their relatives.
- Patients were able to telephone the hospital after discharge, for further help and advice on their return home.

Are medical care services responsive?

Good

Medical care

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Please see core service report for surgery for main details.
- Operational staff from the hospital, including clinical staff, estates and administration, attended regular weekly planning meetings. This ensured patient's care was planned with sufficient staff, and the correct skill mix.

Access and flow

- Consultants saw patients referred by their GP as an outpatient before an endoscopy procedure to check that patients met the admission criteria, assess patients and discuss a plan of treatment. This meant staff could plan the flow of patients. Consultants carried out endoscopy procedures within two to four weeks of referral to the hospital.
- Nurses in endoscopy arranged the treatment lists and contacted the patients to arrange their admission.
- If a patient with medical needs was referred to the hospital, the matron was informed. The matron would ensure a medical consultant was available to accept responsibility for the care and treatment of the patient.

Meeting people's individual needs

- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. During the period February 2016 to June 2016, the hospital's PLACE score for the suitability of the environment for people living with dementia was 92%, better than the national average of 80%.
- The PLACE score suitability of the environment for disabled person, for the same period, was 88%, better than the England average 81%.
- The hospital had a palliative care policy, dated March 2014, which staff would use to guide their practice should any such patients be admitted to the hospital.
- Patients received information relevant to their endoscopy procedure prior to their attendance for treatment. Patients were able to ask questions about their treatment prior to admission should they wish to do so. Patients also had time, on the day of admission and prior to their treatment, to discuss any further questions or concerns they may have had with the consultant or nurses.

Learning from complaints and concerns

- There was a management of patient complaints policy, dated March 2016, that staff used to guide their practice.
- The hospital had received 43 complaints during the reporting period July 2015 to June 2016. CQC have assessed this rate of complaints as similar to other acute independent hospitals for which we hold.
- No complaints had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.

Are medical care services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- See information under this sub-heading in the surgery section.
- Staff in the endoscopy department came under the management of the theatre department. This was a recent change in management structure, which the staff welcomed. Staff in endoscopy told us they felt both supported and valued by their manager.

Vision and strategy for this core service

- See information under this sub-heading in the surgery section.
- The endoscopy department wanted to update and redesign its decontamination room. The current facilities were fit for purpose; however the footprint of the room was small. The desire was to increase the size of the room and introduce new washers.

- Nurses in endoscopy wanted to develop their competencies and become nurse endoscopists.

Governance, risk management and quality measurement (medical care level only)

- The service governance processes are the same throughout the hospital. We have reported the governance processes under this section of the surgery service within this report.
- Department leads from endoscopy and TSSU attended and contributed to hospital governance meetings.
- The lead consultant for endoscopy chaired the endoscopy user group. This group met twice a year with a set agenda. The group discussed ideas such as developing the decontamination room and expanding the service.

Public and staff engagement

- Please see core service report for surgery for main details.

Innovation, improvement and sustainability

- The pharmacy department had developed a visual guide to enable staff to easily identify medicines that may be going out of date. This involved pharmacy staff putting a red or green sticker on medicines which staff understood signified either does not require checking (green) or medicines due to expire (red).
- The pharmacy department had developed a table and chart for patients to take home when discharged. Pharmacy staff would counsel patients regarding taking their medication, the charts were devised to help patients monitor what medications they had taken and when.
- Nurses on the wards had developed patient information boards in each of the private patient rooms. The boards displayed key items of information useful to the patients during their stay. These had been developed following patient feedback and because of questions frequently asked by patients.
- Staff in theatres told us that they use the same equipment as the other hospitals in the local area. This enables a consistent approach to training which nurses told us the consultants, trainee surgeons and nurses find valuable.

Good

Surgery

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

Summary of findings

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.

Staffing for surgery was managed jointly with medical care.

We rated surgery as good because;

- Patients received safe, effective and appropriate care, treatment and support that met their individual needs and protected their rights.
- The care delivered was planned and delivered in a way that promoted safety and ensured that people's individual needs were met. We saw patients had individual risks identified, monitored and managed, and that the quality of service was regularly monitored.
- The clinical environments we visited and other communal areas in the hospital were clean and fit for purpose. Hospital-acquired infections were monitored and reported rates were of an acceptable range for the size of hospital.
- Outcomes for patients were good, and the department followed relevant national guidelines.
- Complaints were investigated and handled in line with a standard policy. We saw the hospital used patient complaints and feedback for service improvement. The hospital encouraged feedback from its patients and their relatives.
- We saw that the World Health Organisation (WHO) five steps to safer surgery checklist was used correctly and its use was embedded in practice.
- Surgical equipment was available and working correctly in theatres.
- The theatres were well managed and managers had the trust and support of their staff, and also had good working relationships with senior staff at the hospital.
- The morning huddle meeting was an effective way to plan for the day ahead and learn from the previous day's events.
- Staffing levels in theatres were appropriate.
- There was an open culture for reporting and learning from incidents.
- The hospital had clear policies and protocols for cleaning and infection prevention and control that staff adhered to.
- Patients were positive about the care they received from all hospital staff.

However,

- Although staff were given time to complete their mandatory training, compliance with this was below the hospitals' target.

Good

Surgery

Are surgery services safe?

Good

We rated safe as good:

Incidents

- The hospital had an incident reporting policy in place for staff to follow which outlined staff responsibilities and risk classification. The hospital staff used an electronic incident reporting system, all staff had access to this.
- Staff we spoke with knew about incident reporting: they knew how to report an incident and had access to the electronic reporting system. Staff gave examples of incidents that had been reported, for example potential drug errors and use of wrong name bands for patients. They told us that they had feedback about incidents in monthly team meetings.
- In the reporting period, July 2015 to June 2016, there were no Never Events and no serious injuries. Never Events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In the same reporting period, there were no deaths.
- In the reporting period, July 2015 to June 2016, there were 120 clinical incidents and 6 non-clinical incidents within surgery services. Nursing and medical staff we spoke with were aware of the reporting system, and staff could describe their roles in relation to incident reporting and investigation. All staff we spoke with said that they received feedback after submitting an incident report. Learning was cascaded via the governance committees and received at staff team meetings.

Duty of Candour

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff were clear about their obligations under DoC and gave us appropriate responses to scenario-based questions.There were no incidents that would trigger a formal DoC response.
- Senior staff told us they had received information and training on the DoC. We saw evidence DoC was discussed in team meetings.

Cleanliness, infection control and hygiene

- Staff had access to infection prevention and control and hand hygiene policies, these were available to staff on the hospital intranet.
- Wards and departments were visibly clean. Cleanliness checklists were completed by housekeeping staff and on display in every bathroom. We reviewed patient led assessment of the care environment (PLACE) results for the hospital and noted 100% for cleanliness, above the national average of 98%.
- The quality improvement manager was the infection prevention and control (IPC) lead for the hospital. There were also link nurses for IPC across all hospital departments. IPC nurses acted as a resource and support and the hospital had a service level agreement with a microbiologist from the local NHS trust to provide expert IPC advice and guidance. The microbiologist attended the Infection Prevention Expert Advisory Group, which met quarterly.
- The IPC link staff held monthly meetings with the matron at the Infection Prevention Monitoring Group and both groups reported to the Clinical Governance Committee
- The hospital had no reported incidents of meticillin resistant staphylococcus aureus (MRSA) or meticillin 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.

Good

Surgery

- The hospital reported 22 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.
- In the reporting period of July 2015 to June 2016, the rate of infections during upper GI and colorectal procedures was similar to the rate of other independent acute hospitals we hold this type of data for.
- For the same period, there were no surgical site infections resulting from primary and revision hip arthroplasty, revision knee arthroplasty and breast procedures.
- The hospital had investigated each 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.
- 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 before and after providing care to patients and using hand sanitising gel appropriately.
- We reviewed the results of the hand hygiene audit undertaken in September 2016 and the inpatients department scored 97% compliance with the provider hand hygiene policy.
- Staff cleaned equipment on the ward and a dated green sticker was placed on all items after the equipment had been cleaned.These labels indicated that re-usable patient equipment was clean and ready for use. Commodes we inspected were clean; equipment was stored in a separate clean utility room. All cleaning products and equipment were stored appropriately.
- The hospital had decontamination facilities onsite, called the Theatre Sterile Supply Unit for managing sterile services and supplies.

Environment and equipment

- Patients were cared for in ensuite private rooms, all rooms had telephones, and wall mounted televisions and cupboards to store patient belongings. The hospital had 43 individual bedrooms for privately funded patient and NHS patients.
- 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 medication and equipment was present and in good working order and all items were within their expiry date. There was documentary evidence daily checks were carried out.
- We checked the contents of the paediatric resuscitation trolley. The listed medication and equipment was present and in good working order and all items were within their expiry date.
- 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 patient controlled analgesia pumps, infusion pumps and ECG machine, and all of the equipment was up-to-date with safety testing.

Medicines

- Pharmacy staff provided a 24-hour on-call service, seven days a week. The resident medical officer was also able to access pharmacy and supply medications out of hours; a standard operating procedure was available for this practice.
- Pharmacists visited the ward daily Monday to Friday to check current stock levels, review pre-assessment medications and discharge medications. Pharmacy staff also saw patients at the time of admission to review their prescription charts.
- Medicines were stored in a locked room, with access restricted to authorised staff. Patients' own medicines were stored in a separate locked trolley.
- Medicines requiring refrigeration were stored in fridges, these were locked and the temperatures were checked daily and staff were aware of the action to take if the

temperature recorded was not within the appropriate range. Emergency medicines were readily available and they were found to be in date. Intravenous infusions were stored in a locked room.

- Controlled drugs are medicines, which were stored in a designated cupboard, and their use recorded in a special register. Records of controlled drugs we reviewed were accurate.
- We reviewed the controlled drugs audit for June 2016 and the hospital scored 99% compliance with their internal policy.

Records

- We reviewed six patient records and saw that all patients had received a nurse-led pre-operative assessment and staff kept legible, accurate, and contemporaneous records.
- Within all six patient records we found that completed risk assessments for falls and pressure ulcers and malnutrition universal scoring tools were complete. All patient records also contained completed venous-thromboembolism (VTE) risk assessments.
- We saw that the had been completed in all six records we reviewed. We observed this was undertaken in theatre and was undertaken in accordance with requirements.

Safeguarding

- The hospital had systems in place for the identification and management of adults and children at risk of abuse. There was a safeguarding children, vulnerable people and adult's policy and procedure, which included guidance on female genital mutilation (FGM) and a named nurse lead for safeguarding for children and adults.
- Staff we spoke with could describe their roles in relation to the need to report and take action when safeguarding issues were identified. There was no safeguarding concern reported to the CQC in the reporting period July 2015 to June 2016.
- Staff received mandatory training in the safeguarding of vulnerable adults and children Level 2 as part of their induction, followed by refresher training. In July 2016, the rate for Level 1 and 2 safeguarding children and young adults training was 90% and for safeguarding vulnerable adults was 93%, against the hospital's target of 100%. The hospital reported that 12% of staff that had completed Level 3 safeguarding training.

Mandatory training

- The mandatory training programme included the following modules, fire training, basic life support, manual handling, blood transfusion, infection control, hand hygiene, PREVENT, children and adults safeguarding and Mental Capacity Act.
- We reviewed the hospital mandatory records published in August 2016, and the completion rate for all staff was 63.8%.
- Mandatory training completion data for the theatre department showed the completion rate was 73%, which was below the company's target of 85% and for wards the completion rate was 85%.
- Consultant staff attended mandatory training at the NHS trust, which was their main employer and this was evidenced through the appraisal process.
- Mandatory sessions could be accessed on the corporate intranet.
- Staff confirmed they were allowed protected time to complete mandatory training including attending annual resuscitation and scenario training. We were told mandatory training was delivered as face-to-face training sessions or via e-learning programmes.
- Staff we spoke with told us they had completed their mandatory training and there were no problems accessing eLearning or face to face mandatory training.

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

- The hospital had admission criteria for patients to ensure only low-risk healthy adults underwent surgical procedures. We reviewed this document and ascertained 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 six patient records and in all cases we found that the news score were completed appropriately.

- The hospital used the use of 5 steps to safer surgery framework (WHO Checklist) and we found correctly completed check lists in all six patient records reviewed.
- 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.
- In the six patient records we reviewed we found 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 completion rate for basic life support training for the ward and theatre department staff was 86%, the hospital target was 85%. In addition 94% of ward staff and 86% of theatre staff had completed intermediate life support training.
- 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).
- 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 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.
- In the reporting period July 2015 to June 2016, there was 1 unplanned return to theatre giving a rate of 0.02 per 100 visits to the theatre. This is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the same reporting period there were 17 readmissions to surgery within 28 days and 17 unplanned transfers of inpatients to other hospitals. The assessed rate of unplanned readmissions (per 100inpatient and day case attendances) was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- The hospital had 100% VTE screening rates in the reporting period July 2015 to June 2016.
- The hospital had no incidents of hospital acquired VTE or PE in the reporting period July 2015 to June 2016.

Nursing and support staffing

- The hospital informed us they used the Royal College of Nursing (RCN) guidelines of 1:7 or 8 nurse to patient ratio and theatres used the Association for Perioperative Practice (AFPP) guidelines. Staffing was reviewed on a daily basis for the forthcoming shifts and adjusted according to clinical need and theatre activity. A weekly capacity meeting was held to review the following week's activity and staffing levels. Skill mix reviews were done when staff left and at each monthly one-to-one with the Matron and Heads of Departments.
- Daily nursing hours were calculated as per the Ramsay safe staffing guidance and were allocated per patient was as: Day case surgery is allocated 2.8 hrs, Inpatient surgical 4.5hrs. Ramsay guidance for staff ratios is 1:5 during the day and 1:7 overnight. Ward staffing was discussed and evaluated at each daily staff meeting to ensure appropriate staffing levels were flexed and achieved. The level 2 (high care) beds were staffed with a nurse ratio of 1:2.
- Ramsay Health Care had introduced a new rostering system called the 'Allocate Health roster'. This allowed Heads of Department to manage rotas, skill mix and staffing requirements and monitor staff sickness and annual leave absences.

Good

Surgery

- The use of bank and agency nurses in inpatient departments was lower than the average of other independent acute hospitals we hold this type of data for in the reporting period July 2015 to June 2016.
- The use of bank and agency health care assistants in inpatient departments was lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period. The rate was 0% in August 2015 to December 2015, March 2016, May 2016 and June 2016 of the same reporting period.
- There were no staff vacancies in theatre departments as at 1 June 2016.
- There were no inpatient staff or other staff vacancies as at 1 June 2016.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that the information shared was clear, with discussion around individual patient's needs and risks, and the plan for their hospital admission and discharge.

Surgical staffing

- The hospital had 86 consultants working under practicing privileges (July 2015 to June 2016). 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 two consultants had practicing privileges removed and two consultants had practicing privileges suspended between July 2015 and June 2016. The hospital had concerns about three consultants practice and, one consultant failed to provide the required 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 RMOs were qualified and experienced doctors trained to registrar level. 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 from the ward manager 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 patients that were unwell. 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 a business continuity plan. This was available to staff on the hospital shared drive.
- We saw the plan, which outlined the process for managing and coordinating the hospital's response to an emergency. Staff we spoke with were familiar with these plans, and had received regular scenario exercises.
- Monthly tests took place on the backup generator and routine fire drills were undertaken.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We saw the service used standardised care pathways for long and short stay patients and patient care was carried out in line with national guidelines such as the

National Institute for Health and Care Excellence (NICE). Policies referenced national guidance and were stored on the shared drive.Staff we spoke with were able to access up-to-date policies on the intranet.

- We reviewed hospital policy documents for example, the medicine management 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 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.

Pain relief

- The hospital used a number of different medicines for relieving pain post-operatively. Information about the medicine prescribed, including how to use it and any side effects was discussed with patients prior to surgery and following their operation. This enabled the patient to communicate effectively with staff and obtain the correct pain relieving medication following their surgery.
- Pain assessment tools were embedded in national early warning scores. Staff completed assessment at regular intervals depending on patient acuity. The six medical records we reviewed reflected that staff completed regular pain assessments and patient received consultant prescribed pain relief.
- We spoke with four patients about pain and patients told us that the nursing staff asked about their pain, and the effect of any painkillers, regularly. They reported that their pain was managed well by the staff.

Nutrition and hydration

- We saw patients being offered drinks and food. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes by using the Malnutrition Universal Screening Tool (MUST) nutritional risk assessment.The documentation we reviewed showed good levels of completion.
- A variety of hot and cold food was available. The hospital had access to food for patients out of hours and there was good choice for patients including vegetarian, gluten-free, lighter options and multi-cultural food choices. Patients had access to fresh water where appropriate and all of the patients we spoke with commented positively about the food. The hospital provided three meals a day plus snacks for in-patients.
- 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.
- In the notes we reviewed, there were accurate and complete records to show patients' intravenous and oral fluid intake and output was monitored following surgery.

Patient outcomes

- The hospital participated in national audits for orthopaedic surgery, breast surgery; patient reported outcome measures (PROMS), Public Health England surgical site surveillance and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) audits.
- We reviewed PROMs data that showed the hospital performed similar to the England average for primary knee replacements (NHS patients) during the reporting period July 2015 to June 2016. Patients having orthopaedic joint surgery were reviewed in outpatient clinics for up to a year following their operations.
- The hospital used the National Joint Registry to record outcomes for patients that underwent surgery such as hip, knee replacements and spinal surgery.
- Local audit outcomes were reported to the Clinical Governance Committee and submitted to the head office to inform benchmarking tools across the group. The ward and theatres completed quality assurance audits on a quarterly basis length of stay, variances in pathway of care, complications, readmission, return to theatre, cancellations and transfers. The results of the audits were shared by the senior management team through staff team meetings.

- The hospital had 17 unplanned re-admissions and 17 unplanned transfers to another hospital between July 2015 and June 2016. The assessed rate of unplanned transfers (per 100 inpatient attendances) was higher than expected when compared to a group of independent acute hospitals which submitted performance data to CQC.
- The hospital had one unplanned case that was 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.
- 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

- There were systems in place to withdraw practising privileges in line with policy, in circumstances where standards of practice or professional behaviours of consultants were in breach of contract. Fitness to practice issues for consultants were assessed and acted upon by the hospital director and the Medical Advisory Committee.
- 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 two consultants had practicing privileges suspended between July 2015 and June 2016 because this evidence was not submitted. In the same period, two consultants had practicing privileges removed because there were concerns with the standards of their practice.
- There was a system to ensure qualified doctors and nurses' registration status were renewed on an annual basis. Data provided to us by the hospital showed 100% completion rate of verification of registration for all staff groups working in inpatient departments and theatres, in the period of July 2015 to June 2016.Staff were aware and felt supported through the registered nurse revalidation requirements.
- 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.
- New staff had an induction relevant to their role. Staff we spoke with said that they had found induction useful and it contained relevant information to help them carryout their role.
- Agency and bank nurses received an orientation and induction to the ward area. This included the use of resuscitation equipment and medicines management. Following this induction staff signed induction checklists.We reviewed two records and noted them to be completed and they covered relevant information.
- Less than 75% of inpatient nurses and other staff working in the hospital have had their appraisal completed in the current appraisals year so far.
- Less than 75% of theatre nurses, ODPs and health care assistants working in the hospital have had their appraisal completed in the same appraisals year so far.
- No inpatient healthcare assistants have had their appraisals completed in the same appraisals year so far. During our inspection, we saw documentary evidence appraisals had been planned for all healthcare assistants.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited and staff were observed to have effective working relationships. A daily huddle meeting took place, whereby representatives from all departments met and discussed updates of activity, staffing, incidents and social news.
- We spoke with the theatre manager about multidisciplinary working and they 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.

- The resident medical officers told us they were in regular contact with the ward nursing staff throughout the course of a day and were able to contact consultants at any time.
- When patients were discharged, a letter was sent the patient's GP to inform them of the treatment and care provided. They also received letters informing them of the cosmetic surgery to be performed on their patient, prior to the procedure being undertaken.
- We saw evidence of external multi-disciplinary teams (MDT) working for example with the local NHS trust during transfers between hospitals and investigation of incidents.

Seven-day services

- The hospital had three operating theatres open six days per week. Operating times were from 8am to 8pm weekdays and were available on Sundays for emergency procedures, as required. There was an on-call rota for key staff groups including theatre staff, senior managers, and imaging staff to support the out-of-hours service.
- Access to physiotherapy services were available six days a week, with emergency cover on a Sunday. Clinical staff had access to diagnostic and radiology services; this was available 24 hours, seven days a week to support clinical decision-making.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care. They were accessible out of hours and nominated a colleague to provide cover when not available.
- There was a Resident Medical Officer (RMO) in the hospital 24 hours a day with immediate telephone access to on-call consultants.
- The pharmacy was open Monday to Friday 8.30 to 5pm.Outside these hours; the RMO could dispense drugs for patients to take home. Any items not kept in pharmacy and needed urgently could be ordered from the pharmacy at the local NHS trust via a service level agreement 24 hours, seven days per week.

Access to information

- Staff we spoke with said they had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records. Computers were accessible on the wards and in departments.
- Diagnostic tests results carried out were available using electronic systems. Staff said they had the necessary access to the picture archiving and communication system (PACS) system should this be required. This meant there would be no delay accessing test results used to assess a patient's suitability for surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a corporate wide consent policy and a deprivation of liberty safeguards policy in place. The consent policy set out clear guidance for staff to follow when obtaining consent, including what steps to take if there was reason to doubt an adult's capacity to consent and taking consent from patients who did not speak English as their first language.
- Consent was obtained from patients prior to the delivery of treatment. We looked at six consent forms during our inspection; consent was appropriately obtained on all the forms we reviewed and these were completed in line with hospital policy and department of health guidance.
- Where patients lacked capacity to make their own decisions, staff told us that they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Training records for the hospital showed 57% of clinical and 70% of non-clinical staff had undertaken the mental capacity and deprivation of liberty safeguards training.

Good

Surgery

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Patients told us that staff were kind and caring towards them. We observed staff interacting with patients in a compassionate way. All patients we spoke with told us they would recommend the hospital to their family and friends.
- Staff in recovery ensured that patients were comfortable and took the time to provide them with additional care, such as giving out warming blankets when required. Staff respected patients' preferences and choices.
- Patients on the inpatient ward provided us with positive examples of the care they received. All patients had drinks and call buzzers located within easy reach. Patients we spoke with told us that staff did not take long to answer call bells.During the inspection, we heard call bells being answered promptly.
- We observed all staff maintaining patients' privacy and dignity.For example, by knocking on doors and waiting for a response before entering, closing doors when carrying out personal care and covering patients to maintain dignity in the anaesthetic room, operating theatre, recovery areas and during transfers between the ward and theatre areas.
- In 2016, the hospital's PLACE score for privacy, dignity and well-being was 86%. This was better than the national average (83%).
- The hospital's FFT scores were similar to the England average of NHS patients, at 98-100% across the period January 2016 to June 2016. Response rates were below the England average of NHS patients across the same period.

Understanding and involvement of patients and those close to them

- We saw that ward managers and nursing staff were visible on the inpatient wards, and patients were able to speak with them. We observed that medical staff took the time to explain to the patient and relatives the next stages in the plan of care.
- 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.
- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risk and benefits of treatment, their discharge arrangements and actions required prior to discharge. Patients said they were aware of whom to approach if they had issues regarding their care, and they felt able to ask questions. There were patient information leaflets available on both Stephen Copeland Ward and Marlow Ward.
- A patient told us "the entire process was very smooth… information about the process was explained very well."
- Staff respected patients' rights to make choices about their care. Patients and their relatives told us they were kept informed about their treatment.

Emotional support

- Staff provided support to patients in a timely, professional way. We observed staff giving reassurance to patients who were anxious when awaiting surgery and responding compassionately to patients with pain and discomfort.
- We observed a nurse reassuring a patient, who had been anxious before surgery.
- Patients were able to have access to their own multi-faith chaplain during their inpatient stay.
- Breast care specialist nurses were involved with patients throughout their care from initial consultation and diagnosis, during their pre-operative assessment, in the anaesthetic room in theatre when required and post-operatively on the ward. These nurses also support cosmetic breast surgery patients.

Good

Surgery

- There was access to a bariatric specialist nurse and dietician. These members of staff visited patients on the ward when this was required to give them additional emotional support and advise pre and post operatively.

Are surgery services responsive?

Good

We rated responsive as 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.
- There were effective arrangements in place for planning and booking of surgical activity including waiting list initiatives through contractual agreements with the clinical commissioning group (CCG). Managers told us they had good relationships with local CCGs.
- 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.
- Staff held a daily meeting to discuss staffing levels and clinical needs. Ward nursing staff and the nurse manager reviewed planned patient discharges in handovers and throughout the shift to assess on-going availability of beds.

Access and flow

- There were 4,796 inpatient admissions and day case admissions in the reporting period July 2015 to June 2016. Of these admissions, 55% were NHS funded and 45% were other funded.Orthopaedic, ophthalmology and dermatology procedures accounted for the largest number of surgical procedures performed in the same reporting period.
- The hospital booked procedures in advance and did not except emergency patients for surgery. This allowed the hospital to plan staffing levels and resources to meet the needs of the expected patient numbers.
- 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 screened 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, received treatment within 18 weeks.
- 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 15 procedures were cancelled within the last 12 months and of these, 100% (15 patients) were offered another appointment within 28 days of the appointment being cancelled.
- There were 730 Level 2 critical care bed days available in the hospital during the reporting period (July 2015 to June 2016). Of these, 92 Level 2 critical care bed days were used, giving an occupancy rate of 13% for the reporting period (July 2015 to June 2016).

Meeting people's individual needs

- Staff risk assessed patients for sensory, psychological and physical impairments during pre-assessment and on admission to ensure appropriate support mechanisms were in place.For example, deafness, sight impairment, learning disabilities, mental health needs and living with dementia.
- There were links between specialist (NHS) nurses and ward staff to ensure continuity of care and support for patients. The inpatient unit and theatre suite were accessible for people with limited mobility and people who used a wheelchair.Disabled toilets were available.
- The hospital had access to a translation service for patients whose first language was not English. Staff told us that translators were booked to attend the hospital to give face-to-face support to patients and staff. During the inspection, we spoke with an interpreter, who had been booked for face to face Arabic interpretation. Staff also told us that the telephone translation service was used and was an option in an emergency.

Good

Surgery

- 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 nutritious and pleasant.
- All post-operative patients received a courtesy call from the hospital post discharge to ensure their recovery was as expected.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. In 2016, the hospital's PLACE score for the suitability of the environment for people living with dementia was 92%, better than the national average of 80%.
- PLACE score suitability of the environment for a disabled person – 88% (England average 81%).

Learning from complaints and concerns

- Patients could raise complaints in person to staff or in writing. There was also section to allow patients to raise a complaint or issue in the hospital's 'we value your opinion' leaflet.
- Formal complaints followed a three-stage process. Stage 1 involved acknowledging the complaint, explaining the process, an investigation and response by the hospital within 20 days. If the complaint was not resolved, it would be escalated to Stage 2. This stage involved a corporate investigation. Stage 3 involved an independent review by the Independent Sector Complaints Adjudication Service (ISCAS), for fee-paying patients, or the Parliamentary and Health Service Ombudsman for NHS patients.
- An acknowledgment letter was sent within two working days of a complaint being received. Where a response to a complaint was not possible within 20 days, a letter was sent to the complainant. Response letters to complainants included an apology when things had not gone as planned. This was in accordance with the expectations of the service under duty of candour requirements.
- The hospital received a total of 43 complaints between July 2015 and June 2016. The number of complaints received by the hospital was similar to the other independent acute hospitals. The hospital had not broken down the complaints data by department.
- No complaints have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.
- Staff we spoke with 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.

Are surgery services well-led?

Good

We rated well-led as good.

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 hospital general manager was supported by a quality improvement manager and operations manager and the ward manager was supported by senior staff nurses.
- 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 manager told us that they were well supported by the hospital matron and they were visible to staff. Staff told us that they felt able to approach the matron with concerns.

Vision and strategy for this this core service

- The hospital vision aimed for the hospital to be the leading provider of health in the local area, by delivering high quality and safe patient centred care. Staff we spoke with were aware of the vision for the hospital and supported this.
- The values for the hospital were called 'The Ramsay way'. These were corporate values and staff had been included in developing the vision and strategy for the hospital. The values included integrity, ownership, positive spirit, innovation and team work.
- The hospital's strategy was documented in the clinical strategy. This outlined the key priorities, which included: improving patient experience and outcome, pre-operative assessment, to promote and sustain appropriate staffing levels and to promote safeguarding of vulnerable members of society.

Governance, risk management and quality measurement

- 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).
- The MAC was held quarterly and chaired by a lead consultant.It was attended by a lead consultant from each speciality with practising privileges, the general manager and matron. Minutes demonstrated standing agenda items covering admission procedure for children, practice privileges, KPI monitoring and trends and pre admission review process. The conditions of practising privileges were monitored closely for compliance and records maintained of appraisal, indemnity insurance and registration.
- We reviewed two sets of senior management team meeting minutes and noted discussion about significant events, complaints, new legislations and policies, clinical performance, the risk register and audit results.
- 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.
- We reviewed the hospital risk register; this had 17 risks documented, and all of these risks had been graded as low risks. 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 was formally reviewed by the head of department (HOD) and clinical governance committee meeting. Risk was also a standing agenda item at the weekly senior management team meeting and was discussed in detail at least once per month.
- Staff we spoke with confirmed that information relating to quality, risk, and governance was shared in team meetings.
- The hospital had 100% completion rate of validation of professional registration for doctors and dentists working or practising under rules or privileges in the reporting period (July 2015 to June 2016).
- The hospital had 100% completion rate of validation of professional registration for inpatient nurses in the same reporting period.

  The hospital had prepared systems to collect data to submit to the private healthcare information network (PHIN).PHIN will start publishing information on hospital and consultant performance from April 2017. The data includes mortality rates, infection rates, hospital readmissions and transfers as well as patient satisfaction survey results.

Public and staff engagement

- The hospital had a variety of mechanisms to gain feedback from patients by means of the friends and family test, patient satisfaction, we value your opinion, direct patient feedback, hot alerts, insurance provider feedback and through complaints and compliments received. 'Hot alerts' was a way of sharing key information with staff.
- The NHS Friends and Family (FFT) scores were similar to the England average of 98%-100% of NHS patients for

the period January 2016 to June 2016. However the response rate at ward level was mainly lower than the England average (between 17% and 40%) in the same period.

- The hospital had mechanisms for staff engagement; these included the staff survey, staff forums, team meetings and newsletters. Staff we spoke with told us that communication was good and they had the opportunity attend staff social events. Staff forums were held every two months, and provided a platform for the senior management to provide feedback and allowed staff to ask questions directly to SMT.
- Staff commitment was recognised by the 'Long Service Awards', whereby the SMT gave all recipients of this award thank you letters, and these were saved in the staff members personal development folder.

Innovation, improvement and sustainability

- Inpatients had access to physiotherapy sessions several times a day which allowed for quicker mobility and shorter stays in hospital.

Good

Outpatients and diagnostic imaging

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

Summary of findings

Outpatient and diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

We rated outpatients and diagnostic imaging as good because:

- The hospital had systems and processes in place to protect patients from harm.
- Infection prevention and control practices were good, and staff followed hospital policies.
- The care environment was visibly clean, well presented and fit for purpose.
- Medicines were managed and stored correctly; administration was in line with good practice and relevant legislation.
- Patient care records were accurate and stored securely in line with the Data Protection Act 1998.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- The outpatient and diagnostic imaging services had sufficient numbers of appropriately trained competent staff to provide a safe service.
- We observed that staff interactions with patients were kind, caring, and considerate and respected their dignity. Patients told us they were put at ease when having their investigation.
- The hospital was responsive to the needs of the population it served. Appointments could be accessed in a timely manner and at a variety of times throughout the day.
- Managers were visible, approachable and effective.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- Please see core service report for surgery for main details.
- There were systems in place for reporting risk and safeguarding patients from abuse.
- Staff in outpatients and diagnostic imaging used an electronic system to report all incidents and in the reporting period July 2015 to June 2016, there were 158 clinical incidents reported across the hospital. Out of these clinical incidents 20% (31 incidents) had occurred in outpatients and diagnostic and imaging. The rate of clinical incidents that took place within outpatients was below the average of other acute independent hospitals we hold this type of data for.
- All reported clinical incidents had been investigated and we saw evidence of incidents being investigated and learning being shared within the team.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). There was a single incident involving ionising radiation that had been reported: this was a no harm incident.
- All reported clinical incidents had been investigated and we saw that appropriate action had been taken.
- There were no deaths and no never events in the reporting period July 2015 to June 2016. Never events are serious, preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures.The occurrence of a never event could indicate unsafe practice.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Senior staff told us they had received information and training on the duty of candour. Staff had knowledge of the DoC, those we spoke with were able to describe the principles of the DOC.They confirmed that they would contact a patient and provide truthful information if errors had been made, they were aware of the legal process that needed to be followed.

Cleanliness, infection control and hygiene

- The hospital had on-line policies in place for infection control and prevention (IPC) and hand hygiene.There was a regular audit of hand hygiene practice, results of which were 99% in July 2016.
- The hospital had an infection control lead that chaired the IPC committee and provided a route for escalation of risks identified. Infection control and prevention training was provided as part of the hospital's mandatory training.
- In line with current best practise the hospital had a 0% MRSA rate (July 2015 to June 2016), which was achieved through an effective MRSA screening programme. In the same period, there was no incident of E-Coli or C.Difficile.
- There were cleaning schedules for the outpatient and diagnostic imaging department, these were fully completed, and all outpatient areas, both waiting rooms and clinical rooms were visibly clean and well maintained.We saw cleaning schedules were fully completed in the outpatients and diagnostic imaging service.
- The patient led assessments of the care environment (PLACE) score for cleanliness was 100% against the England average 98%.
- Hand sanitiser points were available for patients, staff and visitors to use. This encouraged good hand hygiene practice. During the inspection staff we observed adhered to 'arms bare below the elbow' policy to enable thorough hand washing and prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff to use in all clinical areas, to ensure their safety when performing

procedures. We observed staff using them appropriately. We checked the PPE equipment including x-ray protection lead coats during the inspection, and they were clean and in good condition.

- There were 'sharps' disposal bins in in all consultation rooms, and we noted that none of these bins were more than half full. This reduced the risk of needle-stick injury.

Environment and equipment

- The outpatient department at the hospital consisted of 19 consulting rooms, with three procedure rooms. There was a separate area provided for children attending outpatient appointments.This area had a waiting room decorated for children with age appropriate toys.
- The hospitals' physiotherapy suite had seven individual outpatient treatment rooms and two small gymnasiums.
- The diagnostic imaging department consisted of a reception area, waiting room with private changing facilities and x-ray rooms.There was also a magnetic resonance imaging scanner, this was wide bore and suitable for patients that were larger or that suffered with claustrophobia.There were x-ray rooms for fluoroscopy and a dexa scanner (for assessing bone density). All x-ray rooms had up to date risk assessments, and signage to ask women to discuss with staff if they might be pregnant.
- Equipment was visibly clean. The environment was clean and well maintained by hospital cleaning staff, and labelled with the last service date and review date. Equipment had an asset number to ensure the item could be tracked if it required servicing or planned maintenance.
- Electrical safety testing was undertaken annually, and we saw records confirming this. Staff we spoke with were clear on the procedure to follow if items of equipment were faulty or broken. Contractors for the x-ray equipment completed all repair and servicing work.
- Staff did not report any concerns regarding availability or access to equipment. Staff told us senior management was supportive of requests for new equipment.
- The housekeeping team managed the disposal of waste. There was clear labelling of clinical waste bins and sharps boxes we checked in clinical rooms with the date they were put into use.
- Resuscitation equipment in radiology and outpatients was available. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff and was safe and ready for use in an emergency. There were patient call bells in changing areas and toilets.
- In diagnostics and imaging, quality assurance checks were in place for each piece of imaging equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protect patients against unnecessary exposure to harmful radiation.
- During the inspection, we observed that specialised personal protective equipment was available for use by staff within radiation exposure areas. We saw staff wore personal radiation dose monitors.

Medicines

- Medicines were stored and monitored safely in outpatients. Medicines were kept locked in cupboards and the keys were held by the lead nurse on duty. Staff we spoke with were aware of who held the keys. Medicines we checked were in date, the department worked with pharmacy to ensure that stock was rotated.
- There were no controlled medicines kept within OPD and radiology. We found that contrast media was stored securely; this was also in date and ready for use.
- Prescription pads (FP10) to be used by consultants were seen to be stored securely and appropriately on-site.
- Prescription tracking systems were in place in accordance with national guidance and appropriate actions had been taken when discrepancies were identified.
- Refrigerators to ensure medicines were stored at the correct temperature were locked, and temperatures checked daily and recorded.

Records

Good

Outpatients and diagnostic imaging

- Records were held in both electronic and paper formats. There were robust policies for clinical record keeping (review date March 2017) and the security of medical records (review date January 2018). All staff signed a Confidentiality clause, and patient records were only handled by Ramsay staff. There was a standard operating procedure in place for transfer of medical records. There was an annual medical records audit that was undertaken to ensure compliance with the hospital's policies; this was at 92% in July 2016.
- Records were collated 48 hours prior to a booked clinic appointment. This minimised the risk of records not being available. Staff told us that if a patient attended a clinic with no records available, it would be at the consultant's discretion as to whether they would see the patient safely without the records. However, this had not happened in the period July 2016 to June 2016.
- If a Consultant wished to take patient records off site they were required to sign confirmation they will adhere to the policy 'Security of Medical Records outside a Ramsay Health Care Facility IS009'.This policy had a review date of October 2016.
- At the time of inspection we saw patient personal information and medical records were managed safely and securely. We reviewed nine sets of patient records. During clinics, all patient records were kept in a locked office and transferred to the consultant when the patient arrived. Staff told us that they had no difficulty in retrieving patient notes for clinic appointments.
- All the staff we spoke with were aware of their responsibilities around the safekeeping of records and the confidentiality of patient information. Patient identifiable information such as patient records were stored securely in locked cabinets.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across x-rays and imaging department.
- Image transfers to other hospitals were managed electronically via a secure system.
- Processes were in place and followed to ensure the right patient received the correct radiological investigation at the right time. A senior radiographer reviewed all x-ray requests before patients were x-rayed. Consultant radiologists reviewed all GP referrals before x-ray.
- There was a cross checking system in diagnostic imaging that ensured the correct patient identity for the procedure. Reception staff checked patient details on arrival.The radiographer rechecked the patient details and asked any safety questions before taking them through for x-ray or scan.

Safeguarding

- There was an identified lead for adult and children's safeguarding.For adults this was the ward manager. The Quality Improvement Manager was the lead for safeguarding children. Both staff had the necessary training to enable them to fulfil this role.Staff we spoke with were aware of the process of raising and escalating a concern.
- There was also a Ramsay corporate lead that was available for advice.
- The children's safeguarding lead provided Safeguarding Level 3 training at the Hospital, following completion of NSPCC Accredited Course.
- In July 2016, the rate for Level 1 safeguarding children and young adults training was 90% and for safeguarding vulnerable adults was 93%, against the hospital's target of 100%.
- Level 2 safeguarding training was part of the hospital's mandatory training. The compliance rate with this was 98% in July 2016. In the same period, there were 25 staff of 97 that had undergone Level 3 children's safeguarding.
- During the period July 2015 to June 2016, there had been no safeguarding alerts or concerns reported to the CQC.
- We reviewed the hospital safeguarding policies for adults and children: these were up-to-date and offered guidance to staff on what constituted abuse and actions to take.

Mandatory training

Good

Outpatients and diagnostic imaging

- The hospital staff compliance with mandatory training is reported under the surgery core service.
- Staff completed a number of mandatory training modules as part of their induction and updated them in line with the current training policy. Training included infection control, fire safety, conflict resolution, equality and diversity, information governance, children and adult safeguarding (levels 1 and 2), manual handling and dementia awareness.
- There was role specific training for staff in diagnostic imaging. They had a comprehensive induction checklist, and we saw evidence that competencies were checked for individual staff.
- Training was delivered through an online learning package or by face-to-face teaching and practical sessions. Staff reported they completed online learning and booked dates for the practical/face-to-face teaching sessions.
- Staff we spoke with said theyhad sufficient time to complete their mandatory training.

Assessing and responding to patient risk

- Staff knew how to recognise deteriorating patients, and how to escalate and respond appropriately. Patients always had access to a registered medical officer (RMO) RMOs were trained in advanced life support.They provided medical support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would, after consultant agreement, be transferred to the inpatient ward or to the local acute NHS Trust in line with the Ramsey emergency transfer policy. Staff reported this rarely happened.
- Emergency resuscitation equipment was available and was appropriately checked daily as described in the hospitals adult resuscitation policy (date for review March 2019). Patients who had had contrast dye were pre-assessed to the relevant risks to decrease the possibility of an unforeseen reaction to the chemicals.
- There was a separate children's outpatient area, this had resuscitation equipment suitable for children.This was checked daily and recorded.
- Arrangements were in place for radiation risks within the comprehensive local rules. Local rules are the way diagnostics and imaging work in accordance with national guidance.
- In accordance with the ionising radiation (medical exposure) regulations (IR(ME)R 2000), policies and procedures were in place for staff to identify and manage risks. The policies had been reviewed and signed by staff to confirm these had been read and understood.
- Medical physicists advised on radiation safety conducted quality checks. The Regional Radiation Protection Service (RRPPS) provided this service under a service level agreement.
- There was clearly visible and appropriate radiation hazard signage outside the x-ray rooms for staff and patients.
- Imaging request cards and computer system included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation.

Nursing staffing

- There was guidance for safe staffing levels in the outpatient department. All activity was planned to ensure there was staffing to safely cover the clinics running on each day. Staff worked flexibly when there were clinics running on a Saturday.
- There was variable use of bank and agency qualified nurses in the outpatient departments in the reporting period July 2015 to June 2016. Rates were higher than the average of other independent acute hospitals we hold this type of data for in seven months of the reporting period.
- The use of bank and agency health care assistants was 0%, lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period.
- There were no outpatient staff vacancies as at 1 June 2016. The department employed 2.8 whole time equivalent registered nurses and 1.6 health care assistant staff.

Good

Outpatients and diagnostic imaging

- Staff teams had daily meetings to share important updates, such as changes to planned clinics or staffing for the day. Staff told us they were willing to be flexible when needed, and told us patient safety was their priority.
- The rate of sickness for nurses working in outpatient departments was below the average of the other independent acute hospitals we hold this type of data for in the period July 2015 to June 2016.
- The rate of sickness for outpatient health care assistants was higher than the average of independent acute hospitals we hold this type of data for except in November 2015 when it was 0%.
- The rate of outpatient nurse and health care assistant turnover was higher than the average of other independent acute providers that we hold this type of data for (July 2015 to June 2016).

Medical staffing

- Please see core service report for surgery for main details.
- The hospital at the time of the inspection employed 86 consultant staff working under rules or practising privileges. The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager liaised appropriately with the GMC and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics.
- Nursing staff told us that the medical staff were supportive and advice could be sought when needed.
- There was a registered medical officer RMO employed by an external agency, on duty and onsite 24 hours a day, seven days a weeks to provide medical support to the outpatient and imaging departments.
- The hospital radiologists offered an on call service. Radiographers operated and on-call rota to provide x-rays over 24 hours.

Emergency awareness and training

- Staff were aware of their roles and responsibilities during a major incident.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as fire, flood and electrical failure. The business continuity plans were also available electronically.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate 'effective', as we do not currently collate sufficient evidence to rate this.

Evidence-based care and treatment

- Care and treatment was delivered in line with the appropriate guidance and evidence based practice.
- NICE guidelines were sent to all consultants and head of department each quarter. Ramsay Corporate policies and documents were based on NICE Guidance as appropriate. All care pathways used were evidenced based and related to the most current national guidance.
- Staff in in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- Radiation Exposure/diagnostic reference levels (DRL) were audited regularly and evidence of these were seen during inspection.
- Clinical audits were undertaken in diagnostic imaging.An audit plan and the results of these were observed during inspection. These included audits in areas such as; clinical records, pre-assessment care, physiotherapy records, Ionising radiation, optical radiation, hand hygiene and infection control & prevention.
- IR(ME)R audits were undertaken in line with regulatory responsibility,copies of these audits, outcomes, actions and results were seen during our inspection.IR(ME)R incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR(ME)R incidents.

Good

Outpatients and diagnostic imaging

- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure.
- All radiology reports were checked and verified by a radiologist, before the report was sent to the referrer.

Pain relief

- Please see core service report for surgery for main details.
- There was no interventional radiology undertaken at the hospital. In the outpatient department, consultants were able to provide private prescriptions to patients who required pain relief. Patients could collect medications from the on-site pharmacy.

Nutrition and hydration

- See information under this sub-heading in the surgery section.

Patient outcomes

- Please see core service report for surgery for main details.
- The diagnostic imaging department audited annually against IRMER standards, and completed a Radiology Protection audit (RPA).There were no outstanding actions that required an action plan.
- The diagnostic imaging department collected information on images that had been rejected, as the image quality meant they could not be used. We were told that this information was made available to the radiation protection adviser, who could review trends in the number of rejected images and, if deemed appropriate, put in place actions to reduce the number.
- All radiology reports were audited for compliance with the reporting times. Reports were all completed within 48 hours. A designated staff member oversaw this process, and discussed the audit results with the radiologists. This ensured that a robust system was in place to prevent unverified reports causing delay to patient care.

Competent staff

- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- Radiologists in the diagnostic imaging department worked under practising privileges. Practising privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this process, and that of the granting of practising privileges, was seen in the minutes of the medical advisory committee.
- No outpatient nursing staff have had their appraisals completed in the current appraisal year so far, July 2016 to June 2017 as they were not at the half year point. However, 33% of registered nursing staff had an appraisal in the previous year (one person), and there had been 100% staff turnover (three people). All staff had an induction process and checklist to assure assessed competence and familiarity with procedures and policies
- The outpatient and diagnostic imaging departments had link staff for infection control.There was support in place for nursing staff requiring revalidation.

Multidisciplinary working

- There is a daily huddle meeting whereby representatives from all departments meet to share immediate updates of activity, staffing, incidents, social news.This has empowered the departments to enable better engagement and understanding of the needs of each individual department and has offered opportunities for working across departments but within individual scope of practice.For example, the manager of the diagnostic imaging department also managed the physiotherapy service and had encouraged an increase in the number of non-medical referrers for MRI scans.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups.

Good

Outpatients and diagnostic imaging

- If there were unexpected findings following a radiology imaging, the radiologists contacted the referring clinician and the radiographers followed up on the results to ensure if any further action was needed it was completed.

Access to information

- All policies and procedures were accessible via the intranet.
- All images and reports were stored electronically, accessible to appropriate staff.
- Staff we spoke with reported timely access to test results and diagnostic imaging.Results were available for the next appointment or for certain clinics, during that visit, which enabled prompt discussion with the patient on the findings and treatment plan.
- There was a white board in the departmental manager's office that contained details of all clinics that were being run; it also identified what staffing resource was available to give an overview of the department's activity on any day.The board provided a simple visual operational overview during staff handovers.
- X-rays were available electronically for consultants to view in the clinic. The diagnostic imaging department had access to an image exchange portal, which enabled the service to securely access and share images with NHS or other independent hospitals.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment.
- GP referral letters would also be available for private patients, unless self-referring. In each of the outpatient consulting rooms there was secure access to the hospital's digital imaging records, NHS imaging reports, as well as pathology reports.
- Radiographers on-call had access to patients images stored on the electronic system.
- Clinical guidelines and procedures could be found easily by staff on the hospital intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a policy for the deprivation of liberty safeguards, for review January 2019.This covered all aspects of the legislation that staff were required to know what constituted a deprivation of liberty.
- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the staff mandatory safeguarding training. Staff demonstrated good understanding about their role with regard to the Mental Capacity Act. The consent process for patients was well structured, with written information and verbal explanation provided before consent for a procedure was sought. If there was a concern that a patient lacked capacity to make a treatment decision the consultant would undertake a capacity assessment.
- Verbal consent was given for most general x-ray procedures and OPD procedures. Some consultants sought written consent from patients for some procedures.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good

Compassionate care

- Patients in the outpatients and diagnostic imaging departments told us they were treated with privacy, dignity and respect and they felt staff cared for them. The reception desk was located away from the department, so patients were unlikely to be overheard. Patients in x-ray expressed that staff were pleasant and gave them the information they required.
- In 2016, the hospital's PLACE score for privacy, dignity and well-being was 86%. This was better than the national average (83%). There was a policy for privacy and dignity; this was due for review in September 2016. We found that staff acted in accordance with this policy at all times when caring for patients.
- When clinics were running late, staff ensured that patients were made aware of the reason for the delay, offered refreshments, and reading material.

Good

Outpatients and diagnostic imaging

- The hospital's friends and family test (FFT) scores were similar to the England average of NHS patients across the period January 2016 to June 2016. Response rates were below the England average of NHS patients in the independent sector across the same period.
- All the patients we spoke with were positive about the care and treatment they had received. We received comments such as; "Staff are caring", "The staff are thoughtful and understanding", and "The consultant and nurses are very considerate". There were no negative comments from any patients within outpatients and diagnostic imaging services.
- Throughout the inspection, we saw staff speaking in a calm and friendly way to patients. Patients told us staff were helpful and supportive.
- There was a policy in place for chaperoning in the outpatients department. Signs offering patients a chaperone were clearly displayed in all waiting areas and clinical rooms.

Understanding and involvement of patients and those close to them

- The hospital undertook a quarterly survey that asked patients if they were given answers from nurses explained in a way they could understand.Patients were also asked if they were given sufficient information about their condition, care and treatment given, their overall experience and likelihood to recommend.
- Patients told us they had been provided with the relevant information, both verbal and written, to make informed decisions about their care and treatment. There was a team of administrative staff that would help patients with enquires about the cost of treatment and payment options. There had been sufficient time at their appointment for them to discuss any concerns they had.
- During our inspection, we saw there was a wide range of health promotion literature in waiting areas. This included leaflets on; orthopaedics, breast surgery, general surgery, physiotherapy.The diagnostic imaging department provided patients with written information on MRI, DEXA and X-ray procedures.
- We saw patients' families, or carers were welcome to accompany them into their consultation providing the opportunity for a second person to hear what the doctor or nurses told the patient and clarify issues later if needed.

Emotional support

- Patients commented they had been well supported emotionally by staff, particularly if they have received upsetting or difficult news at their appointment.
- Staff told us they spoke with patients who were emotionally distressed, in a private area.
- During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first. For example, one staff member told us they had provided support to a patient who had received upsetting news, and had provided the patient with appropriate support.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of Local people. Outpatient clinics for 14 specialities were arranged to match the demand for each. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.
- The outpatient department operated from 8am to 8pm Monday to Friday, and 8am to 2pm on Saturday.This enabled people who worked during "office hours" to attend outside of these times.
- The department covered a range of specialities :Pain Management 3%, Physician 2%, Dermatology 7%, Gastroenterology 5%, General Medicine 1%, Gynaecology 12%, Ophthalmology 5%, Podiatric surgery 5%, Paediatrics 4%, Cosmetic Surgery 2%, Rheumatology 3%, Orthopaedics 38%, Urology 6%, General Surgery 8%.

Good

Outpatients and diagnostic imaging

- There were waiting areas for outpatient, diagnostic imaging and the physiotherapy departments. The outpatients service has three treatment rooms for minor procedures.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the NHS in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment. There was a dedicated administration team to handle NHS patient bookings.
- The hospital had free Wi-Fi for patients to use. Some of the patients we spoke with valued this. The hospital offered free parking for patients.In outpatient waiting areas there were refreshments and magazines available for patients.

Access and flow

- The hospital met the target of 92% of patients on incomplete pathways waiting 18 weeks or less from time of referral in the reporting period July 2015 to June 2016.Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- More than 95% of patients started non-admitted treatment within 18 weeks of referral in the reporting period July 2015 to June 2016.
- The hospital had no patients waiting six weeks or longer from referral for magnetic resonance imaging, non-obstetric ultrasound and dexa scans (bone density) diagnostic tests.
- Radiologists reported on images and scans within 48 hours of the patients' investigation.
- Patient's appointments were arranged through the consultant's individual secretaries and with the outpatient reception team. If clinics ran late staff ensured that patients where told how long they would be expected to wait and given refreshments.
- NHS patients that used Choose & Book, and were subject to the NHS waiting time criteria, this was managed by the hospital's own administration team.
- The hospital had a very low 'Did not attend' rate.All patients who missed their appointment were followed up and audited. Subsequently, the referrer was notified of the non-attendance of their patient.

Meeting people's individual needs

- Patient's individual needs and preferences were central to the planning and delivery of tailored services.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. In 2016, the hospital's PLACE score for the suitability of the environment for people living with dementia was 92%, better than the national average of 80%.
- The PLACE score for suitability of the environment for a disabled person was 88% this was higher than the England average of 81%.
- Staff recognised the need for supporting people with complex needs.We were given examples of where patients with a learning disability, or that lacked capacity had their needs assessed and taken into account.
- All staff had undertaken dementia awareness training, as part of the mandatory training,
- The department provided information on specific procedures. General information on coming into the hospital was also sent out to patients prior to their appointment.
- All written information and signage, including pre-appointment information was provided in English only. There was a telephone interpreting service available, and staff we spoke with were aware of this and knew how to access this service if required.
- We noted in the radiology waiting area there was a 'Pregnancy Safety Poster' displayed. The computer system in radiology had required fields for screening if a woman undergoing an investigation where there was exposure to radiation. The radiographer was unable to proceed until these questions were completed and this ensured that these questions were always asked.
- Patients did not have access to a multi-faith room, however, all patients had their own rooms and could use this space to practice their faith should they wish to.

Good

Outpatients and diagnostic imaging

- Trained chaperones were available to patients and there was information clearly displayed in the waiting area about the services. Booking staff told us that they were usually booked in advance either via patient or GP request. There was a chaperone policy that was up to date.
- There was comfortable seating in waiting areas. All consulting rooms and communal spaces were accessible to patients that used wheelchairs via a lift. The diagnostic imaging department was on the ground floor and was fully accessible to patients that used a wheelchair.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.
- Patient's comments and complaints were listened to and acted upon in the outpatient and diagnostic imaging service. Information on how to make a complaint was provided in a complaints leaflet, there was no link from the hospitals website. "We Value Your Opinion leaflets" also contained a section that allowed a patient to make a complaint or raise an issue. Staff in outpatients and diagnostic imaging were aware of the complaints procedure. Complaints and feedback and lessons learned were discussed at regular monthly team meetings.
- We saw evidence that complaints were discussed at morning meetings. Complaint themes and key learning was reviewed at the Clinical Governance Committee and disseminated throughout the hospital. Each area had a 'you said, we did' board identifying changes that had been made as a result of feedback from complaints.
- In addition, all complaints, concerns, compliments and themes were discussed within the hospital leadership team monthly meetings, governance committee meetings and within the monthly executive board meetings.
- Staff in outpatients told us if a patient had a concern or a complaint, they would try to deal with the matter there and then. Failing that, they would provide the patient with a feedback card and escalate the issue to their manager. This was in accordance with the hospitals policy on handling complaints.
- Complaints were discussed by the senior management team they were also reported in the Clinical Governance Report submitted to Ramsay corporate each month.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- Managers in the outpatient, radiology and physiotherapy departments had clinical roles and were highly visible and easily accessible. Staff reported good support and guidance from their managers. Managers were passionate about their teams and caring for their patients.
- Staff told us their immediate managers had appropriate skills, qualifications and experience to be able to lead and run departments, and were supportive.
- Staff felt listened to and were confident to raise concerns or suggest improvements to services.

Vision and strategy for this this core service

- The hospital had a clear statement of vision and values, driven by quality and safety. The Berkshire Independent Hospital values statement was "The Ramsay Way". This was; caring, progressive; for staff to enjoy their work and use a positive spirit to get things done. Staff took pride in their work and actively sought new ways of doing things. "The Ramsey Way" encouraged staff to build constructive relationships to achieve positive outcomes; recognition of the value of people was demonstrated through professional and personal development.
- The hospital had its statement of values, based on "the Ramsay way", highlighting the values of integrity, ownership, positive spirit, innovation and teamwork. Staff in the outpatient and diagnostic imaging departments were aware of the vision and values.
- All staff in outpatients and diagnostic imaging demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner.

- Vision and values were discussed and reviewed during hospital leadership team meetings, senior management team meetings and staff forums.

Governance, risk management and quality measurement

- There was a defined governance and reporting structure in the hospital, which departments fed into. Managers from the departments attended the clinical governance committee, heads of department meetings, health and safety committee meetings and the infection prevention and control committee meetings.
- Departments held their own team meetings, in which information was fed back from hospital-wide meetings. We were told that the outpatient department held team meetings every two months, the diagnostic imaging department held meetings every two or three months and the physiotherapy department held weekly meetings, which covered different topics on rotation, such as department news, hospital news, service development and continued professional development. We reviewed minutes of the most recent meetings in each department, which we were told were emailed to all staff.
- There was a quarterly clinical governance committee responsible for monitoring the quality of the services across the hospital. Each of the departments had clinical governance meetings that reported into the overarching governance group. The senior management team had oversight of key performance indicators. We saw minutes of meetings, which confirmed standing agenda items such as number of patient harms, incidents and complaints.
- The hospital managed practising privileges of consultants; please see the core service report for surgery for main details.
- All policies were approved at a local and corporate level. Staff had access to policies in hard copy and on intranet.
- Policies for radiological examination were written up as standard operating procedures.
- Local guidance information was on display in every x-ray room.
- There was a risk register for the hospital. We saw this was up to date and risks were identified and mitigated. Each risk had a named lead that was responsible for the mitigating actions and final resolution. The risk register was monitored monthly through the clinical governance committee and senior management team.

Public and staff engagement

- Patient satisfaction and feedback was encouraged and collected through the use of the Friends and Family test cards, “We Value Your Opinion” leaflet as well as from direct patient feedback.There were also “Hot Alerts” received weekly from patients, these could be positive or negative; the hospital also used insurance provider feedback.
- During our visit we saw there were a number of collection boxes for patients to return their completed feedback cards or they could be returned by post. Survey results were completed by departmental leads, and results communicated back to the teams for action and learning.
- The hospital carried out an annual staff survey, as part of the performance management process. The hospital also had other mechanisms for staff engagement such as staff forums, team meetings and newsletters. Staff told us that communication was good and they had opportunities to attend social events. Staff forums were every two months, and gave staff the opportunity to ask questions and receive feedback from the senior management team.

Innovation, improvement and sustainability

- Most staff reported the hospital supported innovation, with the executive team responsive to requests and suggestions for improvement.
- The General Manager held bi-monthly staff partner forums. This allowed staff partners to ask questions and hear the latest news and business developments.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Ensure that staff mandatory training is compliant to the hospital's own target.