Fulwood Hall Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Fulwood Hall Hospital is operated by Ramsay Health Care UK Operations Ltd. The hospital has 29 beds, four of which are double rooms; the others are single en-suite. Facilities include three main operating theatres with laminar flow, an endoscopy/ minor operations unit and outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people age 16 and over, and outpatients and diagnostic imaging. We inspected surgery and outpatient and diagnostic imaging.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 1 to 2 November 2016, along with an unannounced visit to the hospital on 14 November 2016.

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

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

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

The hospital provided care for medical conditions, children aged 16 and over and care for patients at the end of their life. The numbers of patients treated in the last 12 months was considered insufficient to provide separate core service reports. Where information applied to these patients it was incorporated into either the surgery or outpatients report as appropriate.

Services we rate

We rated this hospital as good in safe, effective, caring, responsive and in the well-led domain.

- There was a good incident reporting culture, staff were aware of how to report incidents and were proactive with actions following an incident. Causes were investigated and changes implemented, where appropriate.
- All departments in the hospital were visibly clean and tidy with hand sanitisers at the entrance to each area. There were infection prevention policies in place that were followed and all staff adhered to the 'arms bare below the elbow' policy during the inspection.
- Staffing levels were planned and reviewed using Ramsay Health Care UK's national electronic rostering management system. The inpatient ward and theatres were fully staffed using Ramsay employees, either substantive or bank.
- The hospital had a comprehensive training package in place for all Fulwood Hall hospital staff. New employees undertook a hospital induction package and mandatory training had high levels of attendance. Staff told us they were well supported to continue their education with a scholarship fund.
- The staff we spoke to during the inspection were passionate about their job and caring. Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital
- The hospital had a robust system for awareness, training and monitoring safeguarding adults at risk of abuse or neglect, and safeguarding children and young persons. Policies were based on national guidelines, and covered a comprehensive range of issues.
- The hospital had four on-site safeguarding leads, including a registered children's nurse (who was also the regional safeguarding lead). They delivered training to level three for adult and children's safeguarding. In addition, monthly safeguarding sessions were delivered with a variety of topics and reflective discussion of cases.

Summary of findings

- A range of care pathways were in place, based on national guidance from the National Institute of Health and Care Excellence (NICE) and the Royal College of Surgeons (RCS). Local and national audits measured outcomes including National Joint Registry and performance related outcome measures (PROMs) for elective surgery.
- The hospital exceeded its indicators for consultant led referral to treatment waiting times for NHS patients. The referral to treatment and the admitted for treatment waiting times were consistently above the standard.
- The staff responded to a patients individual needs using a communications slip included in healthcare records prior to admission. Requirements such as air mattresses, moving and handling equipment or diabetic menu required, per prepared in advance.
- Patient feedback was received from a variety of sources and was positive about the care and treatment received. We received a large number of feedback cards and comments included "Fulwood Hall is amazing, all staff and consultants take time to listen and your care and treatment is to the highest of standards. The hospital is clean and hygienic at all times." One patient told us they were prepared to travel 100 miles to be treated at Fulwood Hall hospital.
- All areas were visibly clean and tidy. Sanitisers and hand washing facilities were available in all consultation rooms. The radiology department had cleaning schedules, which included cleaning equipment after each patient. Infection control audits demonstrated excellent compliance.
- Equipment in the diagnostic imaging department was safe and appropriate for use following Ionising Radiation Medical Exposure Regulations 2000 [IR(ME)R] and IRR99 regulations. Personal protective equipment was regularly checked and safe. All equipment was maintained and regular audits were performed to ensure patient and staff safety.
- Mandatory training rates for permanent staff within the departments were on target for full completion with dates scheduled for staff to complete outstanding training within the rolling twelve month period
- Care and treatment was provided to patients who used the outpatient, physiotherapy and diagnostic imaging departments in a kind and compassionate way. This was reflected in the patient satisfaction survey. One nursing staff member told us they started work early to be able to accommodate the needs of one patient who required an earlier appointment slot due to the needs of the patient's business.
- Patient clinical pathways were standardised. Pathway documents were used for each procedure, which included a specific outpatient procedure care pathway. These took into account guidance and established practice, and included appropriate pre and post procedure checks and follow-up information.
- The hospital was proactive in developing practice and improving patient experience, with a number of initiatives in place. During 2016, the hospital had engaged with external participants and the National Institute for Health and Care Excellence (NICE) in reviewing the quality standards for falls and the clinical guidance on urinary incontinence in women.
- The hospital carried out a quarterly consent audit. Although there were recurring deficiencies identified, such as a lack of clear recording of the patient's and clinician's details, the results between July 2015 and June 2016 showed intermittent improvements in compliance with the policy. However, following concerted efforts by staff the audit in September 2016 demonstrated a significant improvement at 97% compliance with the policy.

However:

- There were no new risks entered on the register since October 2015. Although there was evidence that the management team were aware of their risks and had robust arrangements in place to manage and reduce the risks, these risks were not recorded on any risk register. A number of risks including dementia awareness, falls, and outpatient capacity should have been included. Risk assessments for basic health and safety requirements were in place in all areas but managers had a lack of understanding how to rate a risk appropriately using the likelihood and severity.
- There was a reliance on bank staff to fill unmet need for shifts.

Summary of findings

- We observed incomplete records of weekly water outlet flushing checks, to reduce risk from legionella bacteria, some months' records were missing from the file. Staff told us these checks had been done. Managers informed us that paper records for the missing months had been mislaid and that checks were now in place for the future. However, Legionella sampling had been carried out twice in March and October 2016. We viewed this documentation which confirmed there was no legionella present in the water system.
- At the time of the inspection, there was an approximate two-week wait for reporting of plain film X-rays in the diagnostic imaging department during to staffing issues.
- The hospital recognised that increasing demands for its services was not being matched by the physical capacity of its facilities. There were issues with privacy and dignity in the diagnostic imaging waiting area, physiotherapy and pre-operative assessment clinic rooms. Staff had made efforts to adapt the area and their process to provide privacy and confidentiality. Managers had developed business plans to increase the size of the hospital which were to be reviewed by the board imminently.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Staff were trained in the safeguarding of vulnerable adults and children. A safeguarding culture was engrained in the departments and staff were supported to identify and report safeguarding concerns. Patient records were held securely. There was a higher than average use of bank staff to cover gaps in shifts for nursing and healthcare assistants. A range of care pathways, policies and procedures were in place, based on guidance from the National Institute of Health and Care Excellence (NICE) and the Royal College of Surgeons (RCS). The hospital accommodated pre-admission visits for patients living with a learning disability. This visit aimed to reduce patient anxiety, introducing the nursing team and identifying any specific individual requirements, such as equipment or dietary needs. The hospital engaged with the local community to support service improvement. Groups such as the Alzheimers society, Galloways Society for the Blind and the Preston Muslim society all assisted development of the service.
Outpatients and diagnostic imaging	Good 	Mandatory training rates for permanent staff within the departments were on target for full completion within the rolling twelve-month period. The diagnostic imaging department was involved in multidisciplinary meetings with outpatient consultants to review imaging and reports. Care and treatment was provided to patients who used the outpatient, physiotherapy and diagnostic imaging departments in a kind and compassionate way. This was reflected in the patient satisfaction survey. As a response to a number of complaints in the diagnostic imaging department in 2015, the hospital had implemented an improvement plan. This included recruitment of a new departmental manager. There was a clear improvement in the feedback the department had recently received. The hospital took part in the Ramsay Health Care UK customer service excellence awards scheme. Two staff

Summary of findings

in the physiotherapy department had received awards and a staff member in the outpatient department had two nominations. One staff member told us the award scheme meant that staff 'feel appreciated'.

Summary of findings

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Good

Fulwood Hall Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Fulwood Hall Hospital

Fulwood Hall Hospital is operated by Ramsay Health Care UK Operations Ltd. The hospital opened as a purpose built facility in 1986. It is a private hospital in Preston, Lancashire. The hospital primarily serves the communities of the Preston area. It also accepts patient referrals from outside this area. Fulwood Hall Hospital is one of three Ramsay Health Care UK Operations Ltd hospitals in the Lancashire County.

The hospital's Registered Manager had been in post for five months at the time of inspection, having transferred from a neighbouring Ramsey Healthcare hospital. The manager was registered with the CQC in 29 June 2016. The hospital had a Controlled Drugs Accountable Officer who had been registered for one year.

The hospital had one inpatient ward and was registered to provide the following regulated activities: Treatment of disease, disorder or injury, surgical procedures, diagnostic and screening procedures and family planning.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital had previously been inspected in September 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, three further CQC inspectors, and specialist advisors with expertise in governance, surgery and diagnostic imaging. The inspection team was overseen by Nicola Kemp, Inspection Manager.

Why we carried out this inspection

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

How we carried out this inspection

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

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:are they safe, effective, caring, responsive to people's needs and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Summary of this inspection

Information about Fulwood Hall Hospital

Fulwood Hall Hospital provided a range of surgical procedures and outpatient services for patients aged 16 and over including orthopaedic surgery, neurosurgery, general surgery, ear, nose and throat (ENT), gastroenterology, gynaecology, neurology, ophthalmology, vascular surgery, colorectal surgery, urology, physiotherapy and pain management.

In support, the hospital offers a range of diagnostic imaging including plain X-rays, dental X-rays, fluoroscopy (a technique that uses X-rays to obtain real-time moving images) and arthrograms (imaging of a joint), general ultrasound scanning and ultrasound guided injections, urodynamic testing (assessing function of the bladder and urethra), and barium swallow investigations.

The diagnostic imaging department consisted of an X-ray room and an ultrasound room. A mobile X-ray machine was available for obtaining images of patients on the ward in emergencies and an X-ray image intensifier was available in theatre.

Although the hospital offers computerised tomography (CT) scanning and magnetic resonance imaging (MRI) scanning, these were carried out using a mobile scanning facility operated by another provider within Ramsay Health Care UK, which was not part of this inspection.

The outpatient, diagnostic imaging and physiotherapy departments are located next to each other. There are seven outpatient consultation and treatment rooms used by the department, with a further two consultant and treatment rooms contracted for use by another healthcare provider.

The physiotherapy department offers a range of therapies including musculoskeletal and lower back pain therapies, pulmonary rehabilitation, extracorporeal lithotripsy for tendons and heel pain, acupuncture, gynaecological therapy, pelvic floor and urinary therapy, and hand therapy.

There were eight private consulting rooms supported by an outpatient treatment room, a pre-operative assessment unit, as well as imaging facilities and a physio and sports therapy department.

Four theatre suites provided a variety of surgical procedures, including orthopaedic, gynaecological, general surgical, colorectal and varicose vein surgery. One of the theatres was Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accredited for endoscopy and other procedures, including gastroscopy, colonoscopy and sigmoidoscopy. Spinal injections are also administered in this theatre.

A resident doctor was available on site 24 hours a day, seven days a week

Patient accommodation consisted of a day care facility providing 12 day case pods and, for inpatients, there were 29 private or double, en-suite bedrooms.

Free car parking and disabled access was also available. Visitor's hours were between the hours of 2pm and 4pm and from 6pm until 8pm with extended visiting hours for private patients.

During the inspection, we visited the ward area, surgical day case and operating theatres, outpatients, physiotherapy and radiology. We spoke with 51 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We spoke with six patients and one relative. We also received 45 'tell us about your care' comment cards which patients had completed during and after our inspection. During our inspection, we reviewed 38 sets of patient records.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016, there were 8,540 inpatient and day case episodes of care recorded at the hospital; of these 87% were NHS-funded and 13% funded by other means.
- During the same reporting period, 77% of all NHS-funded patients and 71% of all other funded patients stayed overnight at the hospital.
- There were 30,927 outpatient total attendances in the reporting period; of these 80% were NHS-funded and 20% were funded by other means.

Ninety-four doctors worked at the hospital under practising privileges and there was one resident Medical Officer (RMO) on site at all times. Fulwood Hall Hospital employed 45.2 registered nurses, 18.6 operating theatre

Summary of this inspection

and care assistants and a further 61.8 staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was employed in addition to the Registered Manager.

Track record on safety for the period July 2015 to June 2016:

- No Never Events had been reported by the hospital over the twelve months prior to our inspection. However, there were two incidents that involved the implantation of the wrong intraocular lens and classified as severe harm.
- There were a total of 89 clinical incidents: 80 no harm, four low harm, two moderate harm, two severe harm and one death
- There were three serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli.
- There was one incident of hospital acquired Venous Thromboembolism (VTE) in the reporting period.
- The hospital reported 44 complaints against the service, none of which were escalated to the Parliamentary and Health Service Ombudsman.

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement include:

- CT scanning (for under 18 year olds and wide bore for patients who have claustrophobia)
- Microbiology
- Nerve conduction studies
- Pathology and histopathology
- Pharmacy services
- Registered Medical Officer

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were low numbers of clinical and non-clinical incidents throughout the hospital and no never events. Staff understood their duty to report incidents. Incidents were well investigated; the duty of candour was implemented, where necessary and learning was shared. Staff had access to the electronic system to record incidents and could give us examples of what would be reported.
- The departments were clean, suitable for the services provided and equipment was regularly maintained and in date. Medicines were managed and stored safely, hygiene audits were completed and the diagnostic imaging department had implemented policies and procedures to meet radiation exposure and protection regulations.
- Staff were trained in the safeguarding of vulnerable adults and children. A safeguarding culture was engrained in the departments and staff were supported to identify and report safeguarding concerns. Patient records were held securely.
- Mandatory training rates for permanent staff within the departments were on target for full completion with dates scheduled for staff to complete outstanding training within the rolling twelve month period.
- Sufficient nursing, healthcare assistant and allied healthcare professional staff were rostered for the services provided in the departments.
- Staff had relevant skills to respond to patients who became unwell within the departments and knew how to get emergency assistance.

However,

- The hospital reported high use of bank staff in the outpatient department.
- Figures showed that mandatory training levels for bank staff in the theatre and ward were low.
- The records of water flushing checks for the surgical unit were incomplete.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- A range of care pathways were in place, based on national guidance from the National Institute of Health and Care Excellence (NICE) and the Royal College of Surgeons (RCS). Staff followed policies and procedures, which were based on this national guidance.
- Hospital policies followed in the outpatient, physiotherapy and diagnostic imaging departments was evidence-based and in line with relevant national and professional guidance.
- The hospital had a well embedded audit programme. This was predominantly routine practice checklists such as record keeping, medicines management and infection, prevention and control. . The audit results were consistently positive. On the occasions where audit results dropped slightly, improvements were made the following month. We were told there was no medical involvement in clinical audits.
- Patients were assessed prior to admission for their preferred approach for pain relief. Patients reported that their pain was well managed during their course of treatment.
- A nutrition and hydration week was held at the hospital in March 2016 and a nutrition and hydration goals plan had been implemented, which was developed by Ramsay Health Care UK.
- Staff had the knowledge and skills to deliver care and treatment effectively and were supported by the managers in their continuing professional development. Students on the ward reported positive experiences of their placement, with good support from supervising staff.
- There was a limited, but effective, multidisciplinary approach between the departments with a good working relationship between the staff and consultants.
- The hospital had established thorough processes for appointing and supervising the Registered Medical Officer and for approving consultants to carry out clinical practice at Fulwood Hall Hospital.
- The hospital ensured continuous medical cover using the services of a company that provided a Resident Medical Officer (RMO). Although the hospital did not offer a full seven-day outpatient service, the departments scheduled additional clinics when needed to meet demand.
- Staff were aware of the processes in place for obtaining informed consent, including the need to consider mental capacity assessment if necessary.

Summary of this inspection

- Despite reminders to staff, there were recurring deficiencies identified by the consent audit. These included the clear recording of the patient's and the clinician's details. However, the audit in September 2016 demonstrated a significant improvement at 97% compliance with the policy.

However,

- The hospital did not routinely collect, or analyse, clinical patient outcome data specifically relating to outcomes for outpatient care and treatments.

Are services caring?

Good

We rated caring as good, because:

- Staff spoke to patients and their carers with kindness, in ways that respected their dignity. Nurses told us they felt they had time to be able to speak with patients and felt able to give 100% of their time in caring for them.
- Care and treatment was provided to patients who used the hospital in a kind and compassionate way. This was reflected in the patient satisfaction survey. Between January and June 2016, the NHS Friends and Family test scores were an average of 99%, which was positive.
- Staff supported patients living with dementia or learning disabilities to visit the department prior to treatment to reduce anxiety. The hospital recognised the important role for carers of patients living with dementia or learning disabilities. Carers were able to stay with their relatives and were given free meals in the restaurant.
- Patients were involved in their care. There were given adequate information to understand the treatment being provided and to understand the role of the clinician looking after them.
- Staff provided emotional support to patients who received bad news. Appointments were scheduled for the end of the clinic day to enable the patient to take a longer appointment and in order to ask questions and reflect.

Are services responsive?

Good

We rated responsive as good, because:

- The hospital worked with local stakeholders, including the clinical commissioning groups and primary care providers to understand the needs of the local population and to plan its services accordingly.
- The hospital exceeded its targets for consultant led referral to treatment waiting times for NHS patients. Between July 2015

and June 2016, above 90% of patients were admitted for treatment within 18 weeks of referral for treatment. No patients waited longer than six weeks for a CT scan and only four waited longer than six weeks for an MRI scan.

- The hospital recognised that increasing demands for its services was not being matched by the physical capacity of its facilities. It had developed business plans to increase the size of the hospital which were to be reviewed by the board imminently. In the interim, daily slot utilisation and weekly capacity meetings were held.
- Staff met the individual needs of patients. Translation services were available for people whose first language was not English and staff accommodated the needs of patients to pray or to attend appointments around their work commitments.
- The hospital developed an assistance dogs policy and worked with the Alzheimer's Society and Galloways Society for the Blind to ensure its services were accessible for patients living with dementia or with a disability.
- The number of patients who had their appointments cancelled between July 2015 and June 2016 was equivalent to 1% of the total number of patients seen. Of these, 98% received an alternative appointment within 28 days.
- A communications slip was placed in patients' notes prior to admission that highlighted an individual's additional needs. The ward diary noted requirements such as air mattresses, moving and handling equipment or diabetic menu required, as appropriate.

However,

- There was an approximate two week wait for reporting of plain film X-rays in the diagnostic imaging department at the time of the inspection due to staff holidays.
- There was a risk that patient privacy and dignity could be compromised in the diagnostic imaging waiting area and that confidential discussions with patients could be overheard in the physiotherapy department.
- Increasing demand on the services provided, in conjunction with the physical capacity of the hospital, meant there was little room for appointments or clinics to overrun without affecting the remaining slots.
- Limited information was collected, or available, relating to the clinics running late, cancellations or patients who did not attend appointments. This meant there was a risk that possible trends, which may affect demand on the departments' services, may not be identified.

Summary of this inspection

- The room available for pre-assessment appointments was small and was used by up to four members of staff as well as two patients at a time. We felt that this facility did not offer the best environment to protect patients' dignity and confidentiality.

Are services well-led?

Good

We rated well-led as good, because:

- There was a strong leadership team in place in the hospital. Senior leaders were visible and the majority of staff felt supported by them, although staff were not as aware of the corporate leaders.
- The Ramsay Health Care UK strategy was embedded in the hospital; staff were aware of the strategy and the values.
- There was a governance structure in place, which was supported by appropriate policies and procedures. A comprehensive audit programme was in place.
- The hospital had a clinical governance lead and regular clinical governance meetings were held. The Medical Advisory Committee met quarterly. This meeting included review of incidents, governance reports and accreditation of medical staff.
- Staff consistently reported positive experiences of working in the hospital. Staff said their leaders were visible, accessible and provided them with support.
- Although the recent staff survey had highlighted some areas that needed improvement, managers had created an action plan and began work to improve staff engagement.
- NHS Friends and Family test scores were consistently very high, although the average response rates were low. However, the hospital's patient satisfaction survey also indicated high levels of satisfaction with the services offered.
- The hospital engaged with patients and various different patient groups in developing their services. This included the Alzheimer's society, the Preston Muslim society and the local Healthwatch organisation.
- High numbers of staff worked to the best interests of patients and colleagues and understood how their role contributed to patient care. Staff were supported to develop and could apply to the Ramsay Scholarship Fund to attend training courses.

However,

- The hospital level risk register did not appear to be a live document with no new risks added to the register since

Summary of this inspection

October 2015. A number of risks that we would have expected to see on the risk register over the last twelve months were not on the risk register, including dementia awareness, falls and high bank staffing levels in surgery.

- Although there was a strong emphasis on risk assessments of equipment and procedures within the individual departments, there were no separate risk registers held in the specific departments that identified risks to the operation of the services, control gaps or mitigation actions put in place for the individual services. The hospital risk register did not include risks related to the individual departments.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

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

We rated safe as good.

Incidents

- Incidents were reported by staff using an electronic reporting system. Staff we spoke with understood their responsibility to report incidents and could give examples of when they had done this. One example was given regarding a patient whose level of care had escalated and the nurse had needed to call for a paramedic ambulance for the patient's transfer to hospital. This incident had also involved senior management in the decision making and learning was shared from this with staff on the ward.
- The hospital reported a total of 94 incidents from July 2015 to June 2016. Of which 89 were clinical and five non-clinical incidents. Eighty four clinical incidents were reported as causing no or low harm. The theatre and inpatient areas had recorded 43 clinical incidents. Overall, the rate of clinical incidents was lower than the rate for other independent acute hospitals.
- Departmental and senior managers reviewed and investigated incidents, put in place corrective actions, if necessary, and escalated any risks to the corporate team. Root cause analyses were completed of any serious incidents that occurred.
- Five root cause analysis reports were inspected and we found investigation reports varied in quality. Whilst all investigations had clearly used root cause analysis techniques, the root cause itself was not identified. For example, a root cause was stated as 'Failure to follow procedure' without the question 'why' being repeatedly asked until a root cause was identified. We discussed this with the management team and quality lead who agreed that further improvements could be made. The team had recently attended root cause analysis training and had found this really useful as a prompt to continue improving the quality of the investigations.
- Evidence was seen of actions being taken in response to themes in incidents. For example, a rise in the number of patient falls incidents prompted a review by the 'Clinical Practice Review Group'. Staff were able to talk about the actions currently being implemented to reduce patient falls. The clinical governance committee minutes had many examples of actions taken in each set reviewed.
- We saw there was a positive culture of learning from incidents. An incident had occurred during 2015 where a patient with dementia had been missing from the ward for a short period of time. This had resulted in a new 'Missing Patient Procedure' and action plan being identified for the hospital, which was shared with other Ramsay sites. Other actions arising from this incident included a review of security on ward exit doors, as well as development of a dementia training package for staff.
- Lessons from incidents and complaints were shared in a number of ways. Incidents were discussed in local management and heads of department meetings and regionally in the northern matrons' committee meetings. Staff also had access to lessons learnt briefings from incidents and complaints.

- There were no reports of 'never events' from July 2015 to June 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- However, two incidents that involved the implantation of the wrong strength intraocular lens had occurred and had been classified as severe harm. The hospital management team sought advice from the corporate governance team and were advised not to report either of these incidents as Never Events. The patients in both cases required further surgery to address these errors. Appropriate action had been taken by staff to reflect and learn following the errors.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw examples of duty of candour which were appropriate and timely.
- Senior staff were aware of the duty of candour requirements. Operational staff were less aware of the legislative requirements of the duty of candour; however, staff we spoke with were aware of the principles of the duty of being open and honest. The Ward Manager had delivered duty of candour group training to all clinical staff.
- Mortality and morbidity were discussed in senior management team meetings and medical advisory committee meetings. Minutes reviewed showed this item on the agenda. However, there had been no deaths reported under this provider's care.

Clinical Quality Dashboard or equivalent

- The hospital submitted data to the NHS safety thermometer for NHS funded patients who had received care and treatment. The NHS safety thermometer tool measures a snapshot of harms once a month, indicating risks such as the incidence of falls, pressure ulcers, blood clots, catheter and urinary infections.
- There was one case of hospital acquired Venous Thromboembolism (VTE) or Pulmonary Embolism (PE) between July 2015 and June 2016. The hospital completed patient screening for risk of venous thromboembolism and the percentage of patients screened was above 95% for the reporting period (July 2015 to June 2016). There were no falls with harm, pressure ulcers or catheter and urinary infections reported by the hospital in the same period.
- A safety thermometer was displayed in the theatre staff room, which indicated a reduction in compliance further to incidences of surgical site infection. These findings had been fully investigated through Root Cause Analysis (RCA), with no correlation between cases identified. Responsive measures had been implemented following this as a further precaution.

Cleanliness, infection control and hygiene

- Ward areas we inspected appeared to be visibly clean and were in an orderly state, free from clutter. Housekeeping staff completed daily cleaning tasks and we observed that checklists were completed, signed and up to date for these tasks. Staff told us they would clean pre-admission rooms and day case 'pods' ready for the next day as a priority, covering the ward and in patient area as ongoing and where required during the day
- The hospital had a standard infection control precautions policy in place, which covered areas including: hand hygiene; use of personal protection equipment; safe use and disposal of sharps; and maintaining a clean environment. The policy took into account The Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Infections and Related Guidance from the Department of Health, and National Institute for Health and Care Excellence (NICE 2012) guidance on Infection: Prevention and control of healthcare-associated infections in primary and community care.
- An infection prevention and control environmental audit was carried out each quarter. The results indicated varied compliance between August 2015 and May 2016 (the lowest average compliance rate was 85% with the highest compliance 98%). Where compliance was lower, action plans were put in place to address the issues. The action plans were reviewed at the next audit.
- Infection prevention and control in the hospital was supported by the Ramsay Health Care UK northwest hospitals' infection prevention and control plan. Infection prevention and control meetings were held once a quarter, which were supported by quality regional meetings. The meetings included standing items for review of infection incidents; the outcome of

any relevant audits that had been carried out; issues arising from the environment; general buildings facilities infection control issues; and, review of any relevant updated guidelines and policies.

- There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C.diff) or Escherichia coli (E. coli) at the hospital for the reporting period (July 2015 to June 2016). Patients were screened as part of their pre-operative assessment.
- There had been fourteen surgical site infections (SSIs) in total between April 2015 and March 2016 at the hospital. The rate of infections for primary hip arthroplasty, primary knee arthroplasty, upper gastro-intestinal and colorectal, urological and vascular procedures was above the rate of other independent acute hospitals. The rate of infections during other orthopaedic and trauma procedures was similar to the rate of other independent acute hospitals.
- We reviewed meeting minutes of the monthly clinical governance committee and saw that incidence and monitoring of surgical site infections was discussed and actions recorded. These included actions such as ensuring that regular recording of patients' temperatures were documented during surgery. We reviewed audit records which confirmed the identified actions had been implemented and progress reviewed.
- The hospital had a hand hygiene policy in place. The policy was supported by a quarterly observational hand hygiene audit. The policy took into account the Hand Decontamination Guidelines from Infection Control Nurses Association and Clean Hands Saves Lives from the National Patient Safety Agency.
- Between 1 July 2015 and 30 June 2016 the average handwashing audit scores from July 2015 to June 2016 were above 98%. The audit results indicated that the hospital complied with the National Institute for Health and Care Excellence (NICE) Quality Standard 61. Although staff initials were used to identify those who carried out the audit and those who were observed, there was no indication in the audit results of which areas or departments the audits covered. This meant there was a risk that poor trends in one particular area may not be easily identified.
- We observed staff following the 'arms bare below the elbow' protocol and wearing personal protective equipment, such as gloves and aprons, when delivering care. Gowning procedures were followed in theatre areas.
- Pre-operative MRSA screening swabs were completed for patients prior to their surgery.
- There were enough sinks and hand gels available for handwashing. A hand hygiene policy and regular quarterly audits of handwashing practice on the ward were in place. Aprons and gloves were available throughout the ward and day case area.
- We observed incomplete monthly records of weekly water outlet flushing checks, which were only signed as having been checked in January 2016, February 2016 and October 2016. Weekly flushing of water outlets is recommended to reduce the risk of legionella bacteria. We noted that meeting minutes of the February 2016 Clinical Governance committee had recommended to carry out more frequent legionella monitoring checks. Staff told us that these checks had been done, often more frequently than once a week, however this recording had been missed. Managers informed us that paper records for the missing months had been mislaid and that checks were now in place for the future. However, Legionella sampling had been carried out twice in March and October 2016. We viewed this documentation which confirmed there was no legionella present in the water system.
- The hospital had a Service Level Agreement (SLA) with the local NHS trust for decontamination of reusable medical devices. This meant that the hospital had systems in place to meet nationally agreed standards for continuous improvement in the use and decontamination of reusable medical devices. Reusable medical devices include surgical instruments, such as forceps, as well as instruments for internal examinations, such as endoscopes. Through this, the hospital demonstrated its approach to reducing risks from surgery and improving outcomes in patient safety, clinical effectiveness and patient experience.
- There were arrangements in place for the handling, storage and disposal of clinical waste including sharps. During our inspection, we saw that all sharps bins were signed and dated, but these were not consistently partially closed when not in use.

Environment and equipment

Good

Surgery

- The operating theatre suite was clean, bright and in a good state of repair. Theatre equipment was checked and in good working order. The anaesthetic machine was checked daily and recorded in a log book, following local policy and procedures. We observed complete and current records were maintained for equipment checks.
- Theatre corridors were clean and free from congestion with equipment, with large and well utilised storage areas available.
- In the operating theatre pack room, where surgical sets were stored, staff reported there were occasional problems with small holes or rips in external packaging. We did not see any evidence of this issue having been reported as a risk. However, there was no evidence of any theatre cases having been cancelled as a result of desterilised packs.
- A fridge was available in theatres for storing an emergency standby supply of blood for transfusion. Two units of blood group O was available at all times, meeting statutory guidance.
- Some equipment checked in theatres did not display service stickers. The theatre manager advised that servicing for some theatre equipment was provided by external contract arrangements. The theatre manager provided evidence of all service details from an equipment inventory, which confirmed that all equipment servicing records were complete.
- Security tagged emergency resuscitation trolleys were checked in theatres. These were complete with all required equipment and drugs for resuscitation, including a set of equipment for difficult intubation procedures. All records of daily checks for these were observed as complete and in date.
- A security tagged resuscitation trolley was available on the ward and equipment was checked daily, as well as with a whole trolley check weekly. We saw that out of two months record checks for this, there were only two days not signed as checked.
- A log book of all equipment, such as drug fridges and syringe drivers, was kept on the ward. The log book provided maintenance and servicing records and we saw all these records were checked and up to date.
- A hoist was available for patient use on the ward and this was labelled, with up to date service history details. Staff completed manual handling training as part of their mandatory training, including training for appropriate use of hoists.
- The hospital did not perform bariatric surgery but had equipment suitable to treat overweight patients such as load bearing trolleys and wheelchairs.
- Pressure redistribution mattresses could be ordered for patients at risk of developing pressure damage. Staff we spoke with knew how to access these.
- Patients were seen for pre-operative assessment appointments in a separate clinic. This room had two patient bays, divided by a curtain. The treatment room was small, used by up to four members of staff and up to two patients at a time, and was a challenging working environment. There were wall cupboards, a sink with handwashing gel, personal protective equipment, oxygen cylinder, a nurse's desk and a small foldaway table. We observed patients attending their appointments during our inspection and were concerned that this facility did not provide patients with the best environment to protect their confidentiality and dignity. This had been noted and reflected in business case for the hospitals proposed development.
- The health and safety audit in late 2015 indicated overall compliance of 95%. There was full (100%) compliance on workplace administration safety, plant and equipment, medical equipment, control of substances hazardous to health (COSHH), electrical safety, office areas, manual handling, and first aid, fire safety and evacuation, waste disposal, ventilation, decontamination, mechanical, building fabric and systems, and the management of contractors. Actions were identified to address areas that had not achieved full compliance: occupational health (83%), general workplace safety (97%), medical gases (85%), and water services (92%).
- Patient led assessments of the care environment (PLACE) audits were completed between February and June 2016 and scored similar to or better than the England average, including cleanliness, which scored 100%.

Medicines

- The hospital had a medicines management policy, which provided guidance for prescribing and administration of antibiotics and other medications. A prescribing audit demonstrated 100% compliance for the use and reason for prescribing, in line with the local

formulary. The medicines management policy also outlined directions for the storage, management and prescription of medical gases. We saw this was followed during inspection.

- Medicines for ward and day case use were stored in a locked room in locked cupboards, including stock and take home medications for patients. We checked five drugs at random in the stock cupboard and these were in date and matched stock records. Controlled drugs were kept in a separate locked cupboard, with random checks of three controlled drugs confirming all were in date and stock levels were correct.
- In theatre anaesthetic and recovery rooms, medications were locked in cupboards as directed by local policy. A dedicated pharmacy standard fridge was available for medicines' storage and daily recording of fridge temperatures were complete and up to date. We observed that log books for recording controlled drugs were signed as checked, with records complete and up to date. A log book for staff to 'read and sign' for local updates, Ramsay Healthcare updates and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) was in place, with this signed and dated by staff.
- A service level agreement (SLA) was in place with the pharmacy service of a local acute hospital trust. A medicines reconciliation service was provided by rotational pharmacy staff to the ward, in a service level agreement (SLA) from the local NHS trust. This covered pharmaceutical care for patients at Fulwood Hall Hospital during their inpatient stay, in five half day sessions 9am-12 midday, Monday to Friday. The service did not provide any input to pre-operative assessment clinic, although we were advised that this was under review as part of the ongoing SLA. A pharmacy technician was also on site one morning each week to undertake a weekly medicines stock-take, which included medicine expiry date checks.
- On a daily basis, the pharmacist would review all patients' medications and double check any changes. There were occasions when patients were admitted after 1.30pm and their medication review took place the following morning. The pharmacist would refer to the patients' medication history and GP referral as a source for any changes that may be required for patient medications .These would be discussed with the Resident Medical Officer (RMO), with any changes documented in the patient prescription.
- Pre- labelled medications for standard medicines such as analgesia, laxatives and prophylaxis were supplied by the trust. A secure medicines stock cupboard for routine medications on the ward was re-stocked each week, from supplies at the trust. Email orders for medicines could be requested by secure email from the hospital to trust pharmacy services. There were no concerns with consultants requesting stocks items that were off standard formulary for medicines.
- The pharmacist gave us an example of an issue regarding a patient commencing anticoagulant medication during their inpatient stay. The patient had not been counselled prior to discharge and the patient was later contacted at home. This issue was escalated and the ward manager worked with the pharmacist to implement a checklist to improve safety of patients receiving anticoagulants in the future. Development of this process had started at the time of our inspection.

Records

- The hospital had a medical records management policy in place, which took into account the requirements of the Data Protection Act (1998) and the Access to Health Records Act (1990). This set out responsibilities for all staff members in the creation, handling, storage and destruction of records. It also detailed standards for confidentiality and set out rights to access records. The policy was supported by a Caldicott guardian policy, based on the seven Caldicott principles and a clinical record keeping policy, which set out the minimum data sets to be included within patient records. Information security incidents were recorded on the hospital's incident reporting system.
- The hospital used paper based patient records. There was a robust process in place for the storage and movement of all patient records within the department. Records needed were transferred to wards and departments from medical records each day and were securely stored in the nurses' office and ward areas. During the inspection, we observed that a storage trolley for case notes in the day case area was unlocked and unattended; however, we noted that staff were using the records intermittently at the time. We raised this to the ward manager, who noted this and ensured staff were instructed to maintain security of case notes

in storage trolleys on the ward at all times. On the unannounced inspection we saw case notes were securely kept in storage trolleys in ward and day case areas showing an improvement.

- Except in the situation where treatment was transferred between the hospital and another regional Ramsay Health Care UK site, the hospital did not permit records to be taken off-site and all staff, including consultants, were aware of this policy.
- Patient records folders in each patient room included risk assessment information, patient information on MRSA, philosophy of care, policies and protocols and chaperone information.
- Nine sets of records were reviewed for patients undergoing ophthalmic (eye) surgery. The patient's consent was clearly recorded in each case, with clear indication of which eye the procedure was to be carried out. Patient name, date of birth, address and other demographic information was correctly recorded and all clinical entries were dated and signed by medical staff.
- We also reviewed an additional 12 sets of patient's paper records. All were concise and legible with date, time and signatures completed.
- A hospital wide medical records audit programme was in place which carried out checks quarterly. Between 1 July 2015 and 30 June 2016, this showed a compliance rate of between 85% and 94%. The audits highlighted areas of shortfalls and identified the responsible person and date for completion. There was some indication in the audit findings that similar shortfalls were still being repeated; this meant that actions to improve were not consistently embedded.
- As the audits did not indicate which department or staff speciality were involved it was not possible for us to identify if any of the audit shortfalls related to staff within the outpatient, diagnostic imaging, or physiotherapy departments.

Safeguarding

- The hospital had a number of safeguarding policies in place, which were based on guidelines from professional bodies and the Department of Health,
- The hospital had four on-site safeguarding leads. These included the registered children's nurse (who was also the regional safeguarding lead), the regional adult safeguarding lead, the outpatient department manager, and the physiotherapy manager. The hospital also had a safeguarding link nurse.
- Nursing staff completed safeguarding training to level two, with the Resident Medical Officer (RMO) and department leads completing level three safeguarding for children and young people. Safeguarding vulnerable adults and safeguarding children training was included in core mandatory training and completed by all staff..
- Non-clinical staff who had contact with children and young people were offered training to level two. This meant that staff were able to recognise and report, or obtain additional advice, if they identified a potential safeguarding concern.
- Although the hospital did not treat children under 16 years of age, staff recognised the need to maintain safeguarding children training as children often accompanied adult patients. The registered children's nurse was notified by heads of department when it was known that a 16 or 17 year old patient was due to come into the hospital.
- Safeguarding policies covered a range of safeguarding issues including domestic abuse and female genital mutilation (FGM). Staff were aware to be vigilant for indications of potential FGM or child sexual exploitation. Any concerns of this nature were discussed with the registered children's nurse who decided on any actions to be taken.
- Clinical, non-clinical and administration staff were all aware of the types of issues that would need to be reported as a safeguarding concern or alert. All staff we asked referred to the safeguarding flowcharts displayed throughout the hospital and were aware of the process to follow to obtain advice from the leads or to raise a safeguarding concern via the hospital's incident reporting system.
- A safeguarding calendar for staff training was in place and staff held safeguarding discussions every month, with reflective discussion of cases. Topics on the calendar included child exploitation and PREVENT (one of the four elements of the government's counter-terrorism strategy). FGM was part of these mandatory training sessions with a 90 minute session delivered by the paediatric safeguarding nurse.
- Staff received training in the PREVENT Strategy. As a result of this training, a member of staff at the hospital had identified a patient who had potentially been radicalised. The hospital notified the authorities who intervened with the individual involved. Easy to follow flowcharts for actions to be taken where staff had concerns about patients who may be radicalised where

displayed in the departmental offices. These included contact details for the relevant leads in the hospital and in the police and had been used successfully by staff on at least one occasion. The hospital had three designated PREVENT leads
- The August 2016 monthly clinical services update from the provider identified a revised policy for safeguarding adults at risk of abuse and neglect. This also included a safeguarding topic of the month and lessons learned.

Mandatory training

- The hospital had a mandatory training policy. This was supported by a mandatory training matrix that identified which courses staff needed to complete for their roles and the frequency that each course needed to be repeated. The policy set out employee's responsibility to ensure mandatory training was completed each year.
- Training was delivered through face to face training and e-learning packages for: data protection; emergency management: fire and personal safety; equality, human rights, and workplace diversity; health and safety; prevention of infection; information security; manual handling; non-clinical basic life support; clinical basic life support; and child protection. Nursing staff also completed intermediate life support skills training (ILS) and other clinical skills training, such as for intravenous drug administration and taking bloods.
- The hospital had an electronic system for recording and monitoring mandatory training. The system highlighted any training due in red. The system was observed whilst on site and training due was highlighted.
- Hospital figures indicated 98% of contracted staff on the ward had completed their mandatory training, however, only 32% of bank staff in theatre, and 41% of bank staff in the ward were compliant with this. The hospital were taking actions to improve the uptake of training with bank staff, including messages in wage slips and newsletters. Efforts are ongoing by the HR Coordinators and the Heads of Department to improve further.
- Staff were provided with PREVENT training at their mandatory training which gave them information and awareness about radicalisation.

Assessing and responding to patient risk

- The hospital admitted patients for surgery that were considered low risk. A corporate admission criteria policy was followed using the local organisation's Pre-op Timelines Criteria (2016) document. This document provided a list of medical conditions that would exclude patients, for example trauma patients, bowel screening and patients with pacemakers. Some conditions were referred to matron for acceptance, for example haemophilia. The document also stated that children aged under 18 years would not be admitted for cosmetic or labial surgery. Patients were not rejected on the basis of their Body Mass Index alone.
- Inpatient records reviewed included risk assessments such national early warning scores (NEWS) and venous thromboembolism (VTE). NEWS had been adopted by Ramsay healthcare and adapted to meet needs of services. NEWS were also noted as part of staff handover.
- A sepsis pathway had been reviewed further to national guidance and nursing staff had completed local ward based training sessions as an update for this information.
- In surgical theatres, the World Health Organisation (WHO) Five Steps to Safer Surgery procedures were followed, as detailed in guidance from the National Institute of Health and Care Excellence (NICE). Two surgical patients were observed used this checklist during our inspection, with two WHO checklists observed.
- Records of patients undergoing cataract eye surgery included WHO checklists for cataract surgery, in addition to an inpatient assessment form specifically for patients undergoing this procedure.
- A designated member of theatre staff, generally an Operating Department Practitioner or anaesthetic nurse, acted as a list safety officer in the anaesthetic room. This measure had been put in place in response to an historic never event, with regard to WHO checklist process.
- Theatre policies were available in the theatre office and a copy of the major haemorrhage policy was beside each phone in the theatre department.
- Although the hospital did not treat patients under the age of 16, all staff were trained in paediatric basic life support. The registered children's nurse was trained to European paediatric advanced life support (EPALS) and the Resident Medical Officer (RMO) was trained to advanced life support level.
- The Registered Medical Officer (RMO) and one theatre nurse had completed training in Advanced Life Support (ALS) and Advanced Paediatric Life Support (APLS) skills,

with two theatre staff waiting to undertake this course. All qualified nursing staff completed Intermediated Life Support (ILS) skills training, with healthcare assistants completing Basic Life Support (BLS) training. No theatre staff were trained in transporting critically ill patients for transfer, if this was necessary the hospital called the local ambulance emergency service.

- There was 24 hour cover on site at the hospital from the RMO. The RMO carried a mobile intercom and could be reached throughout the hospital. Where a patient's condition was changing or deteriorating, the RMO would initially review the patient. If the RMO had further concerns, they would raise contact with the individual consultant to discuss further. The RMO advised there was no difficulty in consultants' responses, all were usually available on contact or replied within a short time after contact. There were good communications in place with nursing staff who would initially raise concerns to the RMO.
- In cases where patients required emergency transfer to the local NHS hospital, there were good communications for this with the on call medical or surgical services. A patient transfer case was described where there had been complications following surgery. The RMO had liaised with the on call registrar to co-ordinate the patient's admission via the accident and emergency department.
- The hospital had implemented a falls assessment programme as part of the admission process, to identify and reduce incidents of falls in patients who may be at risk.

Nursing and support staffing

- Staffing levels were planned and reviewed using the providers electronic rostering management system, which embedded indicators for safety and effectiveness. The system enabled heads of departments to manage rotas, shift allocations, annual leave and sickness absences, skill mix and staff requirements including senior cover.
- Staff told us that staffing was reviewed on each shift according to admissions and patient acuity. Shift times were altered to meet the needs of the service and staff worked flexibly; this was confirmed in review of shift rotas during inspection.
- Nursing handovers were held prior to each shift on the ward, incorporating a recorded handover and a written handover sheet. Patient details, including their condition and mobility, medications, allergies, treatment plans and investigations required were discussed during the handover.
- A pre-operative assessment clinic was held on Mondays to Fridays, staffed by a lead sister, three staff nurses and two healthcare assistants. All surgical patients were admitted for planned procedures and patient acuity was determined during pre-operative assessment appointment.
- We saw good practice in the use of association for peri-operative practice (AFPP) guidelines. Staff were allocated to theatre lists based on their skills and competencies. The role of surgical first assistant was not in place at the hospital, however four nurses were due to be seconded to undertake this training from September 2016.
- Staff sickness rates between 1 July 2015 and 31 June 2016 varied with an expected peak during the winter months. Average sickness rates for this period were 6% for registered ward nursing staff, 7% for ward health care assistant staff, 10% for theatre registered nursing staff, and 10% for theatre registered operating department practitioner's.
- Staff turnover rates between 1 July 2015 and 31 June 2016 were low at 3% for registered nursing staff and 1% for health care assistant staff. In the theatre area for the same period, there was a turnover of 13% of nursing staff.
- The theatres and inpatient ward used bank staff when additional staff were required. The hospital did not use agency staff.
- At the time of our inspection, there was a vacancy for a new position of theatre deputy manager. There were three vacant posts for operating department practitioners (ODPs) or registered nurses (RNs) to work in scrub, anaesthetics and recovery areas in theatres. Data provided by the hospital showed the vacancy rate for theatre health care assistants was above the average compared to other similar independent hospitals. However, permanent and bank staff worked flexibly in order to ensure shifts were fully staffed as required.

Medical staffing

- The hospital had one resident medical officer (RMO), a doctor who resides at the hospital and is on call 24 hours per day seven days per week, who was employed by a third party employer. A pre-employment training

file was provided to the hospital before each RMO arrived, for review and sign-off by matron. The RMO in post at Fulwood Hall Hospital had worked at the hospital for 18 months and his file was complete and up to date.

- The RMO usually worked on a ward floor for a maximum of eight to nine hours per 24 hour shift on duty and not receive more than five night calls in a seven day period. There was an escalation process in place to obtain standby relief for a 24 hour rest break, if there was a significant increase in the workload. Whenever possible a doctor who was experienced with the hospital was utilised for 24 hour relief cover.
- The RMO had daily contact with their employer for monitoring of their hours of duty and the number of times they had responded to calls during the night. The employer's medical support team provided ongoing support staff to provide continuity of cover for when the RMO had completed their hours of duty
- The RMO had full access to consultant surgeon and anaesthetist contact details. All consultants with practising privileges at the hospital provided 24-hour on-call cover for patients post-operatively and were within a 30-minute drive time to the hospital. Where a surgeon was not available for a period of time a buddy arrangement was in place with another surgeon within the same specialty or sub-specialty. Where a surgeon was on holiday or unavailable they also ensured that appropriate cover was provided by their surgical colleagues.
- Radiologists provided on-call cover in case of need for urgent diagnostic services.

Emergency awareness and training

- The hospital had a business continuity management policy, which included response and contingency plans for unexpected events. Fire and bomb threat procedures were displayed on office noticeboards in all three departments.
- Staff completed fire safety training as part of mandatory training and were aware of major incident response plans.
- There was a hospital-wide resuscitation team in place for responding to medical emergencies. This was led by the RMO with a team of nursing and support staff, who were all trained in advanced life support skills for adults and children.
- Generators were available if there was a power failure. These were maintained by the hospital's facilities team.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- The hospital's policies and protocols were standardised by Ramsay Health Care UK. They incorporated up to date recommendations and guidelines from the National Institute for Health and Care Excellence (NICE) and other professional bodies including the relevant Royal Colleges. Guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI 2012) were utilised in theatres for checking anaesthetic equipment.
- We saw evidence that updated clinical guidance was reviewed by Ramsay Health Care UK and fed into the hospital's clinical governance and medical advisory committees. A process was in place to determine whether or not the guidance was applicable to the services the hospital provided.
- We saw evidence of current guidelines of treatment being implemented following a medical advisory committee (MAC) meeting. Decisions to change processes were communicated to all staff, including appropriate visiting consultants via letter and email and cascaded through staff meetings. Clinical commissioning groups were also updated.
- Clinical policies and procedures which reflected national guidance were in place for staff to access on the hospital intranet. Care pathways for treatment at the hospital were based on national guidance, including from the National Institute of Health and Care Excellence (NICE) and Royal College of Surgeons (RCS).
- The hospital had a well embedded audit programme. This was largely routine practice checklists such as record keeping, medicines management and infection, prevention and control with no processes for reviewing clinical outcomes. The audit results were consistently positive. On the occasions where audit results dropped slightly, improvements were made the following month.
- We saw examples of additional clinical audits undertaken as part of the commissioning for quality and

innovation (CQUIN). The hospital had a good relationship with its commissioners and used the CQUIN programme to drive improvements and seek quality opportunities. One of these had been to work with NICE to look at how the hospital could become more involved.

- National Safety Standards for Invasive Procedures (NatSIPPS) were being introduced in theatres. NatSIPPS had been developed by NHS England as an additional approach to promote patient safety in surgical care. NatSSIPPS provide a framework for the development of Local Safety Standards for Invasive Procedures (LocSIPPS) by local clinicians and their patients. This would allow the hospital to build on existing standardised patient safety approaches, such as the WHO checklist.

Pain relief

- During pre-operative assessment, patients were asked about their preferred post-operative treatment for pain management and this was reflected in care plans.
- The provider had a post-operative pain management policy that was followed in the hospital. The policy included a pain score tool from one to ten was used for assessment of patients' pain levels. The assessment also took into account current analgesia levels, non-verbal indicators and levels of discomfort.
- Patients were offered pain relief on the ward on a regular basis and told us their pain was well managed following surgery and they had no complaints regarding this.
- Record folders in patient rooms included National Early Warning Score charts for pain, which staff completed. We observed that pain management was also discussed in handover.
- Surgical patients were routinely contacted by telephone 48 hours after discharge and asked whether or not their pain was at an acceptable level, with advice given by a qualified nurse.

Nutrition and hydration

- Ramsay Health Care UK Operations Ltd. had a nutrition and hydration summary and goals document. This was formulated by a nutrition and hydration link nurse providing guidance, leaflets and education for completion of fluid balance charts. Patients were assessed both pre-operatively and as inpatients using the NICE recommended Malnutrition Universal Screening Tool (MUST). A nutrition and hydration week had been held at the hospital between 14 and 20 March 2016 to focus development in this area.
- Patients' nutritional needs were assessed during pre-operative assessments. Patients were offered quick access to appointments, with low waiting times to minimize the length of time they were nil by mouth.
- Training was provided by the Ward Manager on fluid balance completion, with regular dates displayed in staff areas.
- The catering department provided meals to inpatients and staff members and one patient told us that the chef would speak to patients regarding their needs. Managers told us that the chef made daily calls to patients and could provide a range of meals for patients with allergies or food preferences.
- Theatre fasting times were discussed during ward team meetings in March 2016 and noted in the minutes. The plan was to reduce fasting times for patients. Advice was for patients to eat as soon as possible following surgery and if this was not achieved, it should be fully documented in records.
- Patients were asked about their tolerance of diet and fluids in a routine call, 48 hours post discharge. If there were any negative answers to these questions, patients were contacted for further assessment and advice by a qualified nurse.
- A nutrition and hydration audit undertaken in May 2016 showed compliance at 98% which was a positive outcome.
- There were a large number of patient information leaflets available for patients with specific dietary requirements. These included dietary advice for gluten free diets, diabetes and carbohydrates, healthy eating with kidney problems and eating to protect your heart.

Patient outcomes

- Between July 2015 and June 2016, there were ten patient readmissions to surgery within 28 days. This was better than other independent acute hospitals of a similar type.
- There were five unplanned returns to theatre between 1 July 2015 and 30 June 2016. Three of these were post-surgical infections which occurred between July and September 2015. A root cause analysis (RCA) had been completed and there was found to be no correlation between these cases, all had occurred in

different theatres involving different staff and surgeons. Theatre air filters were checked and one was changed as a precautionary measure and decontamination issues were reported from theatres to the local decontamination hub following this finding. The other two returns to theatre were following a fall and for wrong lens surgery

- There were 20 unplanned transfers of patients to other hospitals during the reporting period. This was not high compared to other independent hospitals of a similar type at 1.5% of the number of patients treated. The Resident Medical Officer explained the decision making process and gave us appropriate examples of patient transfers. The nearest acute NHS hospital with an accident and emergency department was approximately two miles from Fulwood Hall Hospital.
- Between July 2015 and June 2016, the hospital participated in national and local audit programmes to measure treatment and care outcomes for a number of conditions. Data was submitted to national audit programmes for the National Joint Registry (NJR) and the global rating scale (GRS) annual report card for endoscopy.
- The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery. NJR data shows that between 1 November 2015 and 31 October 2016, the hospital carried out 308 hip, 434 knee, and 13 shoulder joint replacements with an average patient consent rate of 99.6%.
- Elective surgery performance reported outcomes measures (PROMs) for hip, knee and groin surgery were reported and these outcomes were monitored at the hospital's clinical governance committee.
- PROMs data for primary knee replacement showed, out of 220 records, 80.9% were reported as improved, with 8.2% as worsened. PROMs data for primary hip replacement showed out of 192 records, 87.5% were reported as improved and 7.3% reported as worsened.
- CQUIN audits of patient outcomes for hip and knee joint replacements were similar to other hospitals in the North West region.
- The hospital offered cosmetic procedures such as breast surgery, tummy tuck and rhinoplasty. These patients accounted for 2.8% of the total number of surgical patients treated. There were 239 cosmetic surgery patients treated between July 2015 and June 2016.
- The Private Healthcare Information Network (PHIN) collects data from hospitals to produce information vital safety and quality indicators such as mortality rates, readmission rates and patient feedback. The first performance measures for hospitals are expected to be available from April 2017. Ramsay Health Care UK was working with PHIN to enable data to be provided.

Competent staff

- The hospital also had an induction policy, which was supported by an induction booklet and checklist. The policy set out the responsibilities of all relevant staff members, including the new employee. Staff confirmed induction was completed on recruitment.
- Nursing staff supported student nurses during their student placement on the ward. Student nurses we spoke with told us they had good support from staff as mentors on the ward and spoke positively about their experiences. One student said that all staff communicated and worked well with each other and that it was like a family environment. Following a really enjoyable experience of being on the ward, one student was applying to join the bank staff for the hospital.
- Health Care Assistants were supervised by nursing staff to triage pre-operative assessment survey questionnaires, completed by patients prior to their admission.
- Fulwood Hall hospital had a continuing professional development (CPD) policy in place. The policy set out staff responsibilities to maintain an up to date CPD file. Funding existed for formal learning activities within both the corporate and local training budgets and through the Ramsay Health Care UK Scholarship Fund. Staff could request training through the Ramsay Health Care UK Academy prospectus.
- Consultants applying for practicing privileges, authorisation from the hospital to provide patient care and treatment, were interviewed by the Hospital Manager and the Matron, and had to supply copies of their training certificates. Comprehensive additional checks were also made in accordance with Ramsay Healthcare policies for granting practising privileges. These were reviewed every five years.

- There were procedures in place for reviewing the RMO's suitability to practice, with the Matron reviewing their appropriate training and experience, prior to this being approved by the MAC committee. After appointment, the RMO would complete a period of supervised induction, supported by the Matron, completing related checklists. The RMO completed annual appraisals and reviewed development objectives with the Clinical Medical Lead, maintaining up to date evidence for medical revalidation. A quarterly assessment of this was given to the hospital for feedback. Competency was assured with the RMO undergoing mandatory training. This included advance life support (ALS), European paediatric life support (EPLS), NHS better blood transfusion, infection prevention and control, the Mental Capacity Act and Deprivation of Liberty Safeguards, equality and diversity, safeguarding children (level three), safeguarding vulnerable adults effective teamwork; data protection, manual handling and fire safety.
- The hospital also had a policy in place for responding to concerns about a doctor's practice. It set out the actions to be taken when concerns were raised about any General Medical Council registered doctor in the hospital. It also detailed the level of support that would be provided to the doctor, including retraining should concerns be founded. The policy enabled information to be discussed and shared between the doctor's responsible officer and the GMC liaison officer. The policy did not set out any details about informing other local healthcare providers about the concerns. However, this would be considered on a case by case basis.
- In operating theatres, one of the scrub nurses had become a practice development practitioner, with links to the local university. Theatre nursing and operating department practice (ODP) students were supported whilst on student placement at Fulwood Hall Hospital. Staff in theatres were positive about the opportunities for continuing professional development that were available through Ramsay Health Care UK Operations Ltd.
- Bank staff were regularly used to provide nursing support in theatres and we observed that an induction process was completed and recorded for these staff.

Multidisciplinary working

- There was good communication between the hospital and the local NHS trust. On occasions where patients needed to be transferred to local acute hospitals for urgent care, nursing staff would continue liaison for any further follow up required.
- Pharmacy services were provided to Fulwood Hall Hospital in service level agreement with the local NHS trust. We observed that day to day communications and processes for this service were clear and efficient, with patients receiving appropriate and timely medications for their needs.
- Communications with other clinical services were established, including for physiotherapy, which provided rehabilitation care as inpatient and outpatients services.
- Staff at all levels reported there were good working relationships with consultants and the RMO, who were easily accessible when required.
- The hospital had a GP liaison officer available who would communicate with doctors' surgeries and produced a GP newsletter to keep them updated on progress, staffing and services at the hospital.
- There were communication systems in place for liaison with GPs, district nurses and social care services.

Seven-day services

- The RMO was based at the hospital 24 hours a day, seven days a week. The RMO had access to consultant contact details in case of any further patient advice required. Consultants all were within a 30 minute drive time of the hospital.
- The physiotherapy service provided a six day service for inpatients Monday to Saturday 8am to 5pm. Diagnostic imaging services were provided Monday to Saturday. An on call facility was available for urgent diagnostic imaging services overnight and at weekends

Access to information

- Staff had access to the hospital's policies and procedures and to professional guidelines, on the hospital computer system. A hard copy of the policies was also available in the hospital's restaurant area
- Patient records were available in note trolleys in clinical areas. Discharge letters were completed in a timely way and we observed records of letters to GPs and patients. Patient notes were flagged to alert staff to individual patient needs, such as diabetes, or equipment needs.

- Consultants with practicing privileges were not permitted to remove records from the hospital, which meant that staff had good access to the information required at the point of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had consent to treatment for competent adults and children/young people policy. The policy clearly set out that a person's capacity to consent to care and treatment was on a decision-specific basis. This meant that staff needed to consider a person's capacity to understand the information being given, ability to retain the information to make a decision, to use or consider the information and to be able to communicate their decision. Interpreter services were available if needed.
- Although the consent policy was robust and in line with relevant guidance, the policy we reviewed had expired in January 2016. This was escalated during the inspection. Staff were aware of the policy and how to report any concerns about a patient's mental capacity to consent.
- The hospital developed a flowchart for assessing consent, which had since been shared with and implemented by an NHS acute trust in the region.
- The hospital carried out a quarterly consent audit. There had been an improvement in compliance by staff in the consent process from 77% in July 2015 to 88% in March 2016, followed by a reduction to 84% in June 2016. However, recurring themes of non-compliance related to recording of full patient details on each page of the form; clear recording of the performing clinician's name; and, evidence of the provision of information to the patient. Action plans were in place to remind staff at team meetings about following correct consent procedures. The audit carried out in September 2016 demonstrated a significant improvement at 97% compliance with the policy.
- During inspection we observed consent procedures being followed appropriately. We also reviewed 21 records where we saw consent records were complete and accurate.
- The Ramsay consent policy contained a specific statement regarding patients for cosmetic surgery. This followed the General Medical Council and Royal College of Surgeons guidance and included a two-stage Consent process with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on the decision. Where the two week cooling off period was not possible, reasons were recorded in the patient's medical record. Information on the procedure was given to patients at a different time to the signing of the consent form. All Cosmetic Surgeons and Fulwood Hall staff are fully compliant with this policy.
- The hospital also had a Mental Capacity Act policy and a Deprivation of Liberty Safeguards (DoLS) policy in place. Consent and mental capacity were also taken into account in the hospital's safeguarding adults at risk of abuse or neglect policy. Staff were aware of the policy. Staff we spoke with told us what the processes were to raise a DoLS application but had not done it.
- The hospital had a dementia screening tool. All patients over the age of 65 who were referred to the outpatient department were screened for dementia.
- Mental Capacity Act e-learning training was available and a signature sheet was available for staff to sign on completion at the nurses' station.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Nurses said they felt they had time to care and were able to dedicate all of their time to patient care. Staff spoke of having honesty and openness when communicating with patients. One nurse said that patients want to know that if you say you are coming back in a minute, then you will be.
- The hospital submitted data to the NHS Friends and Family Test and scored mainly better than the England average of NHS patients from January to June 2016. Overall Friends and Family Test scores for NHS funded patients were an average of 99% during this period. The hospital recorded the data as outpatient, inpatient and day case. The monthly data was consistently high scoring with a range of 98-100%. The hospital met its response rate threshold target of 40%; the average response rate for inpatients during this period was 64%. All patient comments were recorded and any negative comments were highlighted in order to promote improvement where possible.

- We observed staff talking to patients and their families in a courteous and helpful way, respecting their dignity. We heard one nurse responding to a patient during a phone call, when they needed to cancel their surgery due to illness. The nurse was reassuring and provided thorough information when talking to the patient, transferring their call immediately in order to rearrange the admission. The patient was informed that the consultant would be advised of the cancellation and the reason for it. The nurse spoke calmly, in a caring and understanding way, taking time to ask if they had everything they needed and not to hesitate to contact for any further advice.
- Staff told us they were more aware of the needs of vulnerable patients, following specific training in this area. We saw written evidence of this in patient's notes, where staff had considered the patients' individual circumstances, identifying relevant issues regarding individual patient care needs.
- A patient told us the care they received was so good they were prepared to travel 100 miles to Fulwood Hall Hospital for further treatment. Another patient stated they were put at ease, everything explained clearly and they were made to feel special.
- Patient led assessments of the care environment (PLACE) audits were completed between February and June 2016 and scored similar to or better than the England average, including food (92%), privacy, dignity and well-being (83%)
- The pre-admission treatment room was used for individual clinic appointments for patients booked for surgery. This room was used by up to four members of staff at a time and two patients, both as an office base and for individual assessments. The room was cramped and there was only a curtain to separate the two patient cubicles. Staff working in the room would often turn on the radio in order to limit patient conversations being overheard. Staff said they managed as best they could in this environment and there had been no complaints from patients. Where it was possible, patients were seen for pre-assessment appointments in rooms on the main ward.

Understanding and involvement of patients and those close to them

- Patient feedback was received from a variety of sources and was positive about the care and treatment received. We received a large number of feedback cards and comments included "Fulwood Hall is amazing, all staff and consultants take time to listen and your care and treatment is to the highest of standards. The hospital is clean and hygienic at all times." and "Staff were extremely caring. Answered all questions. Gave attention when requested. Sympathetic but appropriately firm with aftercare (e.g. getting out of bed after knee replacement surgery) Benefits explained. Beautiful clean facilities, spacious and safe. Day or night attention perfect."
- NHS Friends and Family test data showed high rates of evaluation for service provision.
- Patients told us they had been provided with information about their operation and they knew what to expect from their treatment. Patients felt involved in making decisions about their treatment and choices were explained.
- Nurses introduced themselves when speaking with patients and relatives; patients reported they were treated with respect and were involved in care planning.
- Senior staff told us the patient was always the focus of care and staff gave us examples of how they had supported individual's needs. One example was a patient who presented for surgery and brought her assistance dog. At short notice the hospital found suitable accommodation and the staff left the hospital and purchased a bed and food to enable the dog to stay.
- The hospital had arranged an afternoon tea for members of a local GP practice as a Patient Participation Group. This enabled patients to visit the hospital before their treatment and involve the community.

Emotional support

- The hospital had a number of policies to address the emotional care needs of patients, including a bereavement policy, a palliative care policy and a chaperone policy. These policies reflected the organisation's intention to respect the uniqueness of patients and families' needs, involving them in patient-centred goal setting and care planning.
- One patient told us how they had been able to stay additional days following surgery in order to feel more confident and prepared for discharge home.

- Staff were able to make notes of patients' specific emotional needs to others caring for them using the communication slip added to the healthcare record. Patients were routinely contacted after discharge to offer advice and check on pain levels.
- Patients were supported on discharge with information on how to manage their specific conditions, nurses told us they spent time ensuring patients understood.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital worked with other stakeholders to plan and deliver its services to meet the needs of local people. The hospital's Quality and Improvement Manager met regularly with the clinical commissioning group in contract and service development meetings. This enabled regular review of the hospital's contract, the services offered and identification of local health trends.
- These meetings included discussion of progress towards meeting the hospital's agreed Commissioning for Quality and Innovation (CQUIN) programme. The hospital had achieved a number of CQUIN goals, for example becoming a dementia friendly environment, but was also participation in the working towards falls prevention across the Lancashire region goal.
- A GP liaison manager provided links between the hospital, the local primary care services and the clinical commissioning groups.
- The hospital recognised that increasing demands for its services was not being matched by the physical capacity of its facilities. It had developed business plans to increase the size of the hospital which were to be reviewed by the board imminently. In the interim, daily slot utilisation and weekly capacity meetings were held.
- The hospital had identified a pathway in pre-operative assessment clinic that could be improved. If, during their clinic appointment, it was identified that the patient required an echocardiogram, they would have to return to their GP for a referral. Initial discussions were proceeding with the local acute NHS trust and commissioners to enable an urgent referral to be made that would prevent delays and possible cancellation of surgery.
- A pre-operative assessment clinic was provided five days a week, offering patient assessment appointments prior to their surgery. Patients would be booked for surgery from their consultant outpatient appointment and referred for this assessment. Most patients waited an average of four to six weeks for this, although some could also be seen the week following their outpatient appointment when this was needed.
- Patients had access to patient information leaflets about their condition. Some of this core information, including MRSA, sepsis and preventing wrong site surgery, was provided in patient folders in their individual rooms. Patients said they felt involved in decisions about their care and treatment.

Access and flow

- The hospital had a waiting list and management of patients accessing NHS treatment policy. This set out key principles of how the hospital would manage patients waiting for treatment, with priority given to those with urgent clinical need. The principles incorporated the NHS 18-week referral to consultant-led treatment pathway (with diagnostic tests to be carried out within six weeks). The policy detailed when the 'clock' would stop and start, including for patients who did not attend their appointments.
- The hospital demonstrated consistently high admitted for treatment figures between July 2015 and June 2016. For eleven months, more than 97% of patients were admitted within 18 weeks of referral. In June 2016, they recorded the lowest figure of 94%, which is still above an indicator of 92% for England.
- Patients we spoke with reported positive experience with choose and book system. They had experienced no delays in the appointments system.
- Staff told us they liaised with GP's, community staff and social services to ensure effective discharge to meet patients' needs and ensure a responsive, timely and safe discharge.
- The hospital had cancelled 182 procedures for a non-clinical reason in the 12 months prior to our inspection. Of these, 98% (179) patients were offered

another appointment within 28 days of the cancelled appointment. The number of cancelled procedures was equivalent to only 1% of the total number of procedures between July 2015 and June 2016.

Meeting people's individual needs

- A simple communications slip was developed to identify patients with additional needs. This was attached to the patient record and meant that all staff were made aware of the patient's needs as they progressed through the hospital and treatment pathway.
- We observed that details regarding any individual additional needs were recorded in the ward diary in preparation for patients who were due to be admitted in the coming days. These included an order for a diabetic diet for a patient, an air mattress for another patient and a hoist to aid moving and handling. Individual patient stickers were attached to each request to identify each request.
- There were systems in place to flag up patients being admitted for cataract eye surgery who had additional medical conditions, such as diabetes. Administrative staff would note any flags from referral details and would print these details onto the booking form. This would then be noted in the ward diary on the patient's day of admission. We observed on one day of inspection that medical conditions for three patients had been flagged in this way, in a theatre list of 36 patients.
- Mandatory training for staff included training on equality, human rights, and workplace diversity.
- Interpretation services were available through Language Line for people whose first language was not English. Staff told us the need for an interpreter was usually included on the referral form.
- The hospital supported Muslim staff, and patients, to find a suitable place to pray.
- The hospitals patient-led assessments of the care environment (PLACE) score for the period February 2016 to June 2016 for dementia was 71%. This was worse than the national average (80%) for independent hospitals that have been assessed. However, for the same period, the hospital scored 83% against a national average of 81% for patients living with a disability. We saw that a number of initiatives were in place for improving care of patients with dementia.
- Appointments for pre-operative assessments were offered longer time slots to allow for identifying any patients with particular medical issues. This would include for example, patients who had issues with medications, or diabetes that was not well controlled. Patients completed a questionnaire, which was reviewed by health care assistants, who also completed initial blood test and screening checks. All patients over age 50 completed electrocardiogram (ECG) screening as part of pre-operative assessment.
- The patient's age and medical history, together with the level of surgery being proposed determined the length of appointment time for pre-operative assessment. Patients with no medical history who were undergoing smaller surgical procedures were offered shorter appointments.
- We observed patients undergoing a pre-operative assessment appointment and saw that clear information was provided by nursing staff to patients about their planned surgery, including advice for pre-admission and anaesthetic fasting. Patient questions were answered, including advice for one patient on antibiotic treatment for an infection that this may result in their surgery being postponed. The nurse advised they would need to check this again with the consultant and get back to the patient.
- Where indicated, nurses completed a falls assessment questionnaire and this was included in the patient record. Patients were given leaflets with information about the hospital and their surgery, as well as leaflets regarding deep vein thrombosis
- We saw that additional care systems which had been established for patients living with dementia were being followed by staff, including flags from pre-assessment appointments and ward diary notes. Staff told us they were more aware of the needs of patients in vulnerable circumstances, following their safeguarding and PREVENT training.
- A dementia package had been introduced to provide for the needs of patients who were living with dementia. This would be identified during the pre-operative assessment appointment and further actions would be determined from this. For example, patients would be introduced to a named nurse and offered pre-admission visits to familiarise themselves with the ward areas. The provider was planning to introduce the 'forget-me-not' scheme to develop further support in meeting the needs of patients living with dementia.
- The hospital had engaged with a number of different patient groups, such as the Alzheimer's' society in order to develop understanding of individual patient needs.

Good

Surgery

- Following work with the Alzheimer's Society on 'John's Campaign', the hospital introduced the 'This is me' booklet for relatives and carers to provide details of the patient's personal preferences and needs. It had also developed a separate leaflet for carers 'Working together' to understand how hospital staff could work with, and support, them in the care of their relative.
- Nurses confirmed that an e-learning dementia package had been developed to support them in caring for patients who were living with dementia. They said this issue had been particularly highlighted when a patient with dementia was on the ward, but their relatives had not always been available to stay with them. It was identified from this situation that wider support measures were needed in order to respond appropriately to the individual needs of patients living with dementia.
- A resource box containing information for staff regarding patients living with dementia or were blind was available in the ward clerk's office and this information was cascaded and documented in the ward meeting minutes.
- The hospital accommodated pre-admission visits for patients living with a learning disability so they could familiarise themselves with the environment prior to their treatment. This visit aimed to reduce patient anxiety, introducing the nursing team and identifying any specific individual requirements, such as equipment or dietary needs.
- Further to an incident with a patient, the hospital had implemented and developed an assisted dogs policy to support the needs of people who were visually impaired. This raised staff awareness of assistance dogs and set out the steps to be taken at various points in the patient pathway to accommodate the needs of a patient with an assistance dog.
- The Accessible Information Standard requires providers of NHS care to make information available to patients who have information or communication needs relating to a disability, impairment or sensory loss in a way that they can read, receive or understand. The hospital complied with this standard. A communication slip accompanied patient's notes which indicated to staff any information or communication needs, and easy read leaflets were available for patients.

Learning from complaints and concerns

- The hospital had a management of patient complaints policy. The hospital aimed to acknowledge all complaints within three days and provide a full response within 20 working days. In the period of July 2015 to June 2016, the hospital received 44 complaints. The rate of complaints received was about the same as other independent hospitals we hold data for. No complaints progressed to the Health Service Ombudsman or to ISCAS (Independent Healthcare Sector Complaints Adjudication Service).
- The acknowledgement timescales for these complaints were met. However, eight of the 44 complaints on the log had extension letters sent. We could not determine the length of delays from the log as the 'Date final reply' column was actually the date a response was due by as opposed to the date the final response was sent.
- The Hospital Manager was responsible for responding to complaints; however, investigation of the complaint was assigned to appropriate managers or staff. Details of all complaints were logged on the hospital's incident reporting system; the complaint incident report was updated at regular intervals throughout the investigation. There was also a process in place for patients to escalate the complaint regionally and nationally.
- We reviewed a sample of six complaints. Of these, four were responded to later than the 20 working day target. In all four cases, a holding letter explaining the delay was sent the day before the response was due. The longest delay in a response from this sample was three weeks.
- Complaints were discussed by the clinical governance committee and learning shared with the quality committee group, which was attended by the heads of departments.
- Learning was also shared between the northern Ramsay Health Care UK sites through the northern matron's meetings. Learning from systemic complaints was shared with all Ramsay Health Care UK organisations at a corporate level. Learning was shared with staff in staff meetings, through the 'Lessons learnt' briefing and through the hospital's staff newsletter.
- Lessons learned from complaints were circulated to staff in a clinical services monthly update newsletter. This also included update information regarding policies, pathways, clinical governance and training.

- Staff were given customer service training to assist them in dealing with complaints from patients. Staff told us they attempted to resolve verbal patient concerns at the time they were raised with staff. However, staff were aware of the hospital's complaint policy.
- We were given an example of staff resolving issues and learning from experience. An inpatient who was blind expressed his discomfort that he knew someone was in his room but had not introduced themselves. Apologies were made, the issue was raised and all staff were made aware. Staff told us they now introduce themselves whenever they enter a patients room.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The hospital was led by a general manager, who was supported by a senior management team consisting of the matron, finance manager, operations manager and GP liaison.
- The management team understood the challenges on the hospital to provide good quality care and were open and honest in sharing their concerns. The problem of space and capacity was an issue that was being managed with daily slot utilisation and weekly capacity meetings.
- Managers were encouraged to attend national conferences to provide updated knowledge to the service. The Clinical Lead had attended a NICE conference and a national Health and Safety conference in the 12 months prior to our inspection. The Matron attended a regional matron's network as part of Ramsay healthcare UK. This provided opportunity for sharing developments and learning, with some positive examples of patient experience initiatives from here.
- The hospital had gathered feedback from the staff survey 'My Voice' conducted at the beginning of 2016. Although 75% of staff were satisfied with the senior management team, only 39% of staff believing the corporate team were visible and 35% believed the team listened to and acted on staff views and concerns. Engagement forums were formed with an action plan to address the issues. As a result, a staff ball was planned, with free invitation offered for all staff to attend. The Chief Executive Officer was planning to attend this event to meet and greet the Fulwood Hall Hospital team.
- Senior staff we spoke with during the inspection reported they had good support from Ramsay Health Care UK leaders also, there was good engagement from strategic leaders with staff at the local level. Staff told us that senior leaders were visible and easily accessible. The hospital Matron was new to Fulwood Hall Hospital but not new to Ramsay Health Care UK and there was good communication in place. The hospital Matron had an 'open door 'arrangement and was accessible for engagement with nursing staff and other staff on a day to day basis.
- We observed there was a culture of openness and honesty at Fulwood Hall Hospital, with a strong focus on patient centred care. Staff at all levels had a positive and enthusiastic attitude towards the hospital, consistently reporting positive experiences of working at Fulwood Hall Hospital. One member of staff said they 'never wanted to leave this hospital' and that it was 'lovely working here'; we did not hear any concerns expressed by any of the staff we spoke with during our visit. Staff in theatres and on the ward spoke positively about working for the organisation, making particular reference to teamwork, flexibility and good working conditions within Ramsay Health Care UK Operations Ltd.
- The hospital monitored performance against the Workforce Race Equality Standard. This identified that between April 2015 and March 2016, 1.5% of staff (four individuals) self-reported they were of black or minority ethnic (BME) backgrounds. None of these staff were employed in senior management positions (bands 8 or 9 or visible senior management roles); however, the hospital reported that despite advertising internally and externally applications were not received from people with BME backgrounds.
- The hospital group monitored and reported on compliance with the Equality Act (2010) in relation to employed staff. Ramsay Health Care UK Operations Ltd developed objectives to address equality issues that had arisen in the report.
- We received a number of comment cards from staff who worked at Fulwood Hall Hospital. The comments included "I feel that I was quickly accepted and integrated into the team. All staff are extremely friendly"

and "As an employee… I have always been treated with dignity and respect." "As an employee I feel a very valued member of the hospital. I work in a safe and hygienic place. I have also had two operations here and had fantastic care from every department. Dignity was always there"

Vision and strategy for this this core service

- We were told about the 'Ramsay Way' and how the values were lived and breathed by all staff. Staff were able to give examples of how these values contributed to their roles. Evidence of a recent interview was provided where the Ramsay values and knowledge of the company was part of the score criteria to support valued-based recruitment. Whilst the appraisals were not directly linked to the values, 'Understanding of Ramsay' is a category and looks at the member of staff's understanding and application of the company vision.
- One of the strategic work-streams was around growth of the business. However, the capacity of the hospital was at its limit. We were told that a business case had been submitted to obtain funding to increase the physical space. The risk to meeting this objective was not on the hospital risk register. We discussed this with the senior management team who acknowledged that this key risk and the actions they are taking would benefit from being recorded and managed via the risk register. The Senior Management Team immediately added four related risks to the register and demonstrated that they had been risk scored appropriately.
- The hospital had a regional business strategy for 2016/17 called 'The Northern Blitz Spirit Strategy'. The view was for all Ramsay Health Care UK hospitals in the region to work to improve the care provided. People were placed at the heart of the strategy, which focused on effective engagement with patients, staff, consultants and stakeholders in order to understand and respond to the needs of the local health care economy. The strategy aimed to ensure robust and comprehensive governance arrangements were in place, including processes, people and planning, in order to provide effective services to patients. Alongside this, a clinical strategy was developed in July 2016 to align with the five CQC domains of safe, effective, caring, responsive and well led.
- Both strategies were supported by the six 'Ramsay Way Values', and the 'Six Cs of Nursing' (care, compassion, competence, communication, courage and commitment), and by a hospital business plan for 2016/17. The plan focussed on growth, cost control, governance, a 'one big thing', improvement of market intelligence, operational detail, and 'our people'. Among the key elements identified in the plan was development of the physical hospital, to provide additional clinic capacity within the outpatient department and the continuing review and development of the diagnostic imaging department.
- Operational staff were aware of the Northern Blitz Spirit Strategy by name, however not all staff seemed sure what the strategy meant. We saw that information about the strategy was included in the staff information we observed on site, including display on staff notice boards and publication in the staff update newsletter.
- Operational staff were aware of the hospital's 'Ramsay Way' vision and values and were able tell us about these. The hospital's values were displayed at the reception desk and on the ward.

Governance, risk management and quality measurement

- Staff were unaware of risk registers or how to get a risk on the risk register. Risk assessments for basic health and safety requirements were in place in all areas and there was an assumption that these were risk registers.
- During the inspection, the senior management team were initially unable to adequately demonstrate an understanding of how to rate a risk appropriately using likelihood and severity. A number of risks that we would have expected to see on the risk register over the last twelve months were not on the risk register, including dementia awareness, falls and high bank staffing levels in surgery.
- However, we could see clear evidence that the management team were aware of these risks and had robust arrangements in place to manage and reduce the risks. Further, following discussion of this, the Senior Management Team immediately added four related risks to the register and demonstrated they had been risk scored appropriately.
- The hospital level risk register did not appear to be a live document with no new risks added to the register since October 2015. The hospital had a risk register, which, in August 2016, identified 20 open risks, including financial, environmental and clinical risks. The 'risk names' were all generic as opposed to being applicable to the hospital. The majority (15) of the open risks were

opened in January 2014. The risk register assessed the inherent, residual and acceptable risk ratings; also identified the accountable executive, responsible manager and next review date for each risk.

- However, we saw that the risk descriptions on the hospital system were poor in terms of describing the status, cause and consequence of the risk. Additionally, the hospital level risk register did not indicate any control measures already in place, or identify any measures needed to mitigate the risks identified. The risk ratings were inappropriate and in a case, we reviewed with the senior management team actually aimed to increase the likelihood of the risk. It was acknowledged by the senior management team that the risk register was not an accurate record of their key risks and how they were being managed. This was an area the team were keen to address. During the inspection, the management team had begun work on a revised risk register based on the existing risks and this revised approach demonstrated improvement.
- Following the inspection, actions were taken including improved training of senior staff by the general manager, a super user to ensure a consistent approach. In addition, the Risk Register was reviewed at all meetings including Senior Management Team, Heads of Department, Clinical Governance, Health & Safety and Medical Advisory Committee Meetings. At these meetings risks were reviewed, additional risks identified, risks were downgraded/upgraded/archived in line with current circumstances. The risk register became a live system, which was constantly reviewed and amended. Furthermore, at a Ramsay corporate level, the risk register was being reviewed by the Group Safety and Wellbeing Manager and the policy was under review.
- The hospital had a committee structure, including a clinical governance committee and medical advisory committee. Evidence was seen in both committees of sharing lessons learned from other hospitals in the Ramsay group
- The clinical governance committee met bi-monthly. Standing agenda items discussed included review of incidents, never events and complaints. Reports from each of the clinical groups in the hospital regarding new clinical, professional and other guidance and legislation, lessons learnt and any new hospital policies. Clinical performance and audit results and patient satisfaction results.
- Meeting minutes of the clinical governance committee were detailed, capturing discussions and information shared at the meetings. However, actions were not given timescales for completion and appeared to be regularly carried over, with no assessment of the risk posed by the actions not being undertaken in a timely way. Attendance at the committee was reasonable and the meeting was chaired by a Consultant Urologist. The Consultant Chair was positive about the contribution of clinicians in the clinical governance arrangements and enjoyed the positive impact he felt his unpaid role had. We were given examples of when the Chair had been required to have discussions with his consultant colleagues to address complaints or incidents. A positive team culture was described amongst the clinical staff. The Chair of the clinical governance committee was also a member of the medical advisory committee (MAC), to highlight any clinical governance issues. We could see this arrangement working via the minutes.
- Medical advisory committee (MAC) meetings were held quarterly. Standing agenda items included review of the general hospital update, review of the clinical governance report and complaints. The MAC Chair's report, surgery cancellation rates, review of any new procedures or standard operating procedures, and credentialing of new consultants. As part of this, arrangements were in place by the MAC for checking and confirming consultant's indemnity insurance in line with legislation, the consultant's qualifications and registrations. Actions arising from the various meetings, and the responsible person, were clearly recorded in the minutes of the meetings. Outstanding actions were reviewed at each meeting.
- We discussed practising privileges with the Chair of the clinical governance committee and were told that he couldn't remember a consultant having their privileges suspended. The MAC Chair however, was able to give us an example of a suspension and explained in detail the process for monitoring the medical staff practising privileges and fitness to practice. Neither the MAC nor the clinical governance committee discussed the risk register. The Chair of the MAC had knowledge of the current risks and progress of actions but acknowledged they were not on a formal register.
- Senior management meetings were held weekly. These included review of hospital activity, review of senior management team monthly reports, clinical

performance, business developments, incidents and audit results. Information from these meetings was shared by department managers with staff in team meetings.

- The hospital had a risk assessment policy in place, which was based on the Management of Health and Safety at Work Regulations 1999, in line with the requirements of a number of other regulations. The policy detailed responsibilities for each member of staff and set out the actions to be taken to assess risk, to record and to score risk assessments
- The departments had detailed risk assessments in place for the environment, systems, use of equipment and some clinical procedures. The assessments clearly identified the hazards related to each assessment, the risk score and mitigating actions or controls that were in place. Where further risk factors or mitigating actions were needed to reduce the risk an action owner and target completion date were identified. We reviewed a range of risk assessments across all three departments; they were all within date and appropriate.
- Staff were aware of their responsibilities in reporting risks and we saw they were proactive in doing this. Managers communicated openly with staff, providing support for staff to report incidents within a "no blame" culture.
- There were a wide range of audits carried out in the hospital as part of the yearly audit programme for 2016/17, which included all departments. Although there were some clinical speciality specific audits, it was not always possible for us to disaggregate the data for the departments in general audits, such as hand hygiene and infection prevention and control.
- The hospital had a facility rules policy. Compliance with the policy was mandatory for all consultants, staff and accredited healthcare professionals. The rules assisted in the selection and granting of admitting rights and / or practising privileges to a health care professional. The rules required an appropriate person to examine the credentials of various categories of healthcare professionals; define and authorise a scope of clinical practice appropriate to the professional's competence, performance and the needs of the facility in which they worked; undertake ongoing assessment of the competence and performance of the professional; and, if necessary, re-define the authorised scope of clinical practice.

Public and staff engagement

- The hospital gathered feedback from patients in a number of ways. The 'We value your opinion' leaflet (which also provided details of how to complain); through the hospital's patient satisfaction survey results; and from the NHS Friends and Family test (which asks patients to rate how likely they would be to recommend the service to their friends and family).
- Fulwood Hall Hospital held a patient participation group's hospital tour on 5 May 2016. This provided the public with information about the hospital, including a tour of the facilities and afternoon tea. These had been well attended and positively received, with plans for similar events to be held in the future.
- The hospital had engaged with a range of community groups, inviting them in to the hospital to support service improvement. This had included meetings with the Alzheimer's society in the development of its dementia friendly policy and carer's leaflet. It had also worked with Galloway's Society for the Blind in developing its assistance dogs policy. Other community engagement had involved Preston Muslim society and local Healthwatch organisations.
- The hospital took part in the Ramsay Health Care UK Operations Ltd customer service excellence awards scheme. Two staff in the physiotherapy department had received awards, and a staff member in the outpatient department had two nominations. One staff member told us the award scheme meant that staff 'feel appreciated'.
- In January and February 2016, a staff survey 'My Voice' had been undertaken. The results were analysed against other Ramsay locations and published in a report. The most positive, highest scoring answers for Fulwood Hall hospital included: working for the best interests of the patient (98%), understanding what was expected of their role (96%), staff understanding their impact on delivering patient care (95%), knowing how to deal with safety issues (91%) and recommending the hospital to friends and family (88%).
- The report provided the top five responses that required action and the management team responded with the creation of an action group. The responses for action were; I feel my pay is fair (30%), I am satisfied with my the physical environment (57%), The corporate leadership team listen and act of views and concerns (35%), I receive recognition (54%) and I have the

resources to do my job (62%). We saw evidence in meeting minutes of proposals from the engagement group, and an action plan with targets, progress ratings and responsibilities assigned to individuals. Both the local management team and the corporate leaders responded to the survey and improvements were in progress.

- As a result of the staff engagement forums, Once a month, the hospital delivered 'month-end madness' for staff. This provided recognition for their work and took a different form each month; for example, the provision of ice-cream, a meal in the restaurant, or toffee apples or Easter eggs for staff. Senior staff told us that staff were receptive to this, and there were good turnouts to other events organised by the hospital.
- The hospital had a staff development funding policy in place, the 'Ramsay Scholarship Fund'. This enabled staff to apply for financial support through the Ramsay Health Care UK Scholarship for courses costing more than £500. Staff were permitted up to three days' paid leave per year for study or examinations relating to courses undertaken through the fund.
- The hospital had a disclosure of information (whistle-blower) policy. This set out the procedures to follow with internal disclosures and with disclosures to regulatory bodies. Staff were aware of where to find hospital policies if needed on the intranet, and in the library in the staff canteen.

Innovation, improvement and sustainability

- The hospital was proactive in developing practice and improving patient experience, with a number of initiatives in place. During 2016, the hospital had engaged with external participants and the National Institute for Health and Care Excellence (NICE) in reviewing the quality standards for falls and the clinical guidance on urinary incontinence in women.
- The hospital was introducing a clinical practice review group. The group, which was to consist of multidisciplinary staff across the hospital, would review previous incidents and reports against current policies and guidelines. This would enable identification of areas that needed to change and would promote learning and information sharing.
- The hospital had developed a new 'Missing Patient Procedure' after a patient with dementia was found to be missing from the ward for a short period. Actions following this were shared with other Ramsay Healthcare UK Operations Ltd sites, as well as development of a dementia training package for staff.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- The outpatient and diagnostic imaging department had 46 clinical incidents and five non clinical incidents between 1 July 2015 and 30 June 2016. This was similar to the rate of incidents for other independent health providers that we hold data for. There were no never events reported in the outpatient and diagnostic imaging department.
- All staff we spoke with were aware of the incident reporting system and understood their responsibility to report incidents.
- Due to the nature of outpatient consultations and limited treatment, there were no specific safety goals set by the department. However, we were assured by the Outpatient Manager that safety of patients was paramount for staff.
- There were no patient deaths related to care and treatment received in the outpatient department. As such, the department was not involved in mortality or morbidity reviews.
- We saw evidence that incidents were shared with the Medical Advisory Committee and the Clinical Governance meetings. Lessons learnt were shared with staff in staff meetings, and through the lessons learnt five circle briefing.

Duty of candour

- Senior staff were aware of the duty of candour requirements. Operational staff were less aware of the legislative requirements of the duty of candour; however, staff we spoke with were aware of the principles of the duty of being open and honest.
- We saw evidence of the appropriate application of the duty of candour relating to an incident within the diagnostic imaging department. Because of a patient label error, a patient received a minimal but avoidable X-ray radiation exposure. The incident was appropriately reported to the regulatory organisations, investigated and the root cause of the error identified. The referring consultant spoke directly with the patient, apologised and reassured them that any risk associated with the X-ray was minimal. The hospital subsequently wrote to the patient providing an explanation of what happened and an apology.
- Learning from this incident was shared with the consultant and the nurse directly involved and resulted in the creation of an information leaflet for consultants to reduce the likelihood of a similar incident occurring in the future. It was also discussed at the diagnostic imaging team meeting.

Cleanliness, infection control and hygiene

- All departments were visibly tidy and clean with hand gel sanitisers at the entrance of each area. Sanitisers, hand washing facilities and sterile wipes were available in each consultation and treatment rooms. Personal protection apron dispensers were available throughout the departments. We saw staff following the 'arms bare below the elbow' requirement of the policy.
- A cleaning schedule and log was in place in the diagnostic imaging department. Staff cleaned clinical

equipment after each patient. Non-clinical areas were cleaned by the housekeeping team. Green stickers were used to identify equipment that had been cleaned and was ready for use.

- The hospital had a screening policy for patients who had MRSA (methicillin-resistant staphylococcus aureus). All patients due to receive treatment in the outpatient's department were screened for MRSA. Patients were swabbed and any MRSA positive screening results were notified to the patient's GP. Following treatment for MRSA, patients were rescreened before outpatient treatment for their condition was started. This meant treatment may be delayed if the patient remained positive for MRSA.
- Within the diagnostic imaging department, patients with MRSA or other suspected communicable infections were allocated appointments at the end of the clinic following which the area was cleaned. This reduced the likelihood of transmission of infection.
- The outpatient department were compliant with the Department of Health's technical memorandum on decontamination of flexible scopes. The remainder of equipment used was disposable. The diagnostic imaging department had a decontamination procedure in place for the use of ultrasound probes used in trans-vaginal scanning.

Environment and equipment

- The design, maintenance and use of the facilities and equipment within the department kept people who used the hospital services safe. Risk assessments, including control of substances hazardous to health (COSHH) risk assessments, were in place for equipment and chemicals in use within the departments. We reviewed a number of these which were detailed, up to date and included mitigation and control factors where appropriate.
- We checked a range of physical equipment in the outpatient clinic treatments rooms. All portable electrical appliances, except one weighing scale, had been tested appropriately and labelled with the date when testing would be next required. The hospital's maintenance team held a log of tested equipment. We highlighted the expired weighing scale to staff for checking against the maintenance log. All disposable equipment (such as dressings or swabs) we inspected on the treatment trollies in each consultation room and the storeroom were within the manufacturers' expiry dates.
- A resuscitation trolley was located in the outpatient department. Daily checks were carried out for the automatic defibrillator and suction machines. The contents of the trolley were checked once a week, after which the trolley was secured with a new tamper tag. We checked the equipment in the trolley, which, except for one suction tube, were within the manufacturers' expiry dates. Staff immediately replaced the date expired suction tube; we confirmed it had been done.
- In the diagnostic imaging department clear, illuminated, 'radiation in use' warning signs were in place by doors leading into any area where radiation equipment was used. This reduced the likelihood of staff or members of the public entering the area while equipment was in use.
- Detailed risk assessments were in place for each piece of radiation equipment within the department. These included assessment of risks to staff and patients, staff training in the use of each piece of equipment, signage to ensure mitigation of risks (for example door to be closed) and action plans for maintenance and repair.
- Processes were in place to ensure specialised personal protective equipment (PPE) was available and used by staff within the diagnostic imaging team. All staff members within the diagnostic imaging department were issued with a personal radiation dose monitor badge. Each badge was sent off every three months to be checked centrally by the radiation protection advisors, and the individual staff member's dose exposure was recorded. Staff were working within the safe limits.
- Visual checks of personal protective equipment such as lead aprons were carried out regularly and results were logged. The personal protective equipment had been replaced in April 2016; therefore, due to the risk of unnecessary additional radiation exposure, X-ray checks to determine if there were any breaks in the protective material were carried out only if there were visible signs of damage. Personal protective equipment checks were included in the departments audit against the Ionising Radiation Medical Exposure Regulations 2000 [IR(ME)R] and IRR99 regulations. The audit results in May 2016 indicated 93% compliance by the department, with one of the areas of weakness relating to X-ray checks of

personal protective equipment. This was due to concerns about radiation exposure to staff in carrying out these checks; as a result, the department put in place a staff rota to carry out the checks in order to reduce the risk of radiation exposure.

- A contract was in place between Ramsay Health Care UK and a medical equipment and services provider for the maintenance of diagnostic imaging equipment. This meant equipment was repaired in a timely way minimising any impact on the department.

Medicines

- The management of medicines in the outpatient and diagnostic imaging departments kept people who used the services safe. The hospital had a medicines management policy; staff were aware of the policy and how they could access it.
- Medicines in the outpatient department were stored in a locked cupboard. The room's temperature was recorded and logged using a maximum/minimum thermometer. Medicines which needed to be stored at a lower temperature so they were effective were stored in a locked fridge. Fridge temperatures were checked and logged daily using a maximum/minimum thermometer; the temperatures recorded were consistently within the appropriate range of two to eight degrees Celsius. We reviewed a sample of six different medications held which were all within the manufacturers' expiry dates and appropriately labelled if opened.
- Staff told us of one occasion when, due to a fault with the air conditioning, the room temperature increased. Staff appropriately took advice from a pharmacist on whether or not the medications held in the room needed to be removed; in this event no further action was needed.
- Medicines in the diagnostic imaging department were stored in a locked cupboard within the X-ray room. Medicines stored by the diagnostic imaging department included contrast media (an intravenous liquid used to enhance the internal images of the body) and anaphylaxis kit. We checked a range of medicines within the cupboard. All medications were within the manufacturers' expiry dates.
- The department's FP10 prescription pads were stored securely under lock and key. The department achieved full compliance with this in the twice-yearly audit.

Records

- There were systems and processes in place in the departments to ensure the management of people's records were accurate, complete, legible, up-to-date and stored securely. We reviewed thirteen sets of patient care records within the outpatient department. All were of good quality. Referrals, relevant history, patient consent, plans of care, decisions and, where appropriate, discharge summaries were all clearly recorded.
- The hospital reported only 1% of records were not available for clinic appointments. In this situation, there was a process in place to print any electronic letters held and placed into a temporary record for the consultant to use in clinic. Temporary records were subsequently destroyed. There were no reported clinic cancellations within the department due to records being unavailable.
- The diagnostic imaging department held records within the picture archiving and communication system (PACS). Referring consultants also had access to this system which meant that copies of the images and the diagnostic imaging reports were directly available to consultants. The department had a procedure in place for requesting access to patient images held by other healthcare organisations through the PACS image exchange portal system if needed.
- At the time of the inspection, the department was in the process of integrating a new digital PACS system. Although this improved response times for accessing and reviewing new images, staff were concerned about delays caused in the retrieval and accessibility of older images that were stored on the old system. Staff told us this was a known national problem with the PACS system supplier at its data centre, which meant there were delays in the robotic retrieval of image data from the data tapes. This meant there was a risk that older images would not be available in a timely manner for review by medical staff, if needed. This was a known risk that was included in the department's risk register.
- We reviewed four sets of patient records in the physiotherapy department. The records were of good quality, were legible, signed and dated. A clear patient history and care plan was recorded, which included assessment of previous treatment and patient pain.

Safeguarding

- Safeguarding flowcharts were displayed throughout the outpatient, diagnostic imaging, and physiotherapy

departments, including in staff offices and in clinic rooms. The flowcharts provided easy to follow guidance for staff on the appropriate response to safeguarding or FGM concerns, including contact details for safeguarding leads that were able to provide advice.

- All staff in the outpatients and diagnostic imaging departments had completed safeguarding vulnerable adults and safeguarding children training which was included in the mandatory training programme. Nursing staff completed safeguarding training to level two, and the Resident Medical Officer (RMO) and department leads completed level three safeguarding for children and young people. Non-clinical staff who had contact with children and young people were offered training to level two.

Mandatory training

- Staff undertook mandatory training twelve months after previous completion. At the time of our inspection, 98% of all permanent hospital staff had either completed their training or were scheduled onto future training dates within the rolling twelve-month period. For staff in the outpatient and diagnostic imaging department; 80% of outpatient staff, 66% of physiotherapy staff, and 57% of diagnostic imaging staff had completed mandatory training. Dates had been scheduled for the remaining staff to complete their training within the rolling schedule. It was therefore expected that the departments would achieve full compliance.
- At the time of our inspection, the mandatory training completion rate for bank staff in the outpatient, physiotherapy and diagnostic imaging departments was 87%.However, not all bank staff were used on a regular basis. There was a process in place to schedule mandatory training when these bank staff were next employed; this also included updating staff on new policies and procedures.

Assessing and responding to patient risk

- The outpatient department had a resuscitation trolley available for use in emergencies. Pocket cardiopulmonary resuscitation masks (used to safely deliver rescue breaths during a cardiac arrest) were available throughout the hospital.
- Although the hospital did not treat patients under the age of 16, all staff were trained in paediatric basic life support. The registered children's nurse was trained to European paediatric advanced life support (EPALS) and the Resident Medical Officer (RMO) was trained to advanced life support level.
- Due to the nature of the work undertaken in the outpatient department, staff were less likely to encounter deteriorating patients. However, the Registered Medical Officer could be contacted by a two-way radio to attend any deteriorating patient in the departments. A sepsis pack and flowchart had been introduced to the department to assist staff in the identification of possible sepsis.
- The hospital had common policies and procedures in place that set out details of diagnostic imaging staff responsibilities shared with staff of the mobile MRI and CT scanning provider. These included the MRI safety policy, medical emergencies in scanner policy and medical emergency/arrest on mobile scanner policy.
- The hospital had two radiation protection supervisors; the diagnostic imaging manager and the senior radiographer. The supervisors were supported by Ramsay Health Care UK radiation protection advisers. The advisers were available on call to provide advice.
- Two radiation protection adviser audits were carried out in 2016. The audit in February 2016 concluded that the department was 'partially compliant [with current regulations] with a number of minor improvements necessary'. The audit made 12 recommendations to be completed by April 2016; none of these recommendations were repeated in the subsequent audit in October 2016.
- The October 2016 audit indicated that the department had improved and was 'nearly fully compliant [with current regulations] with only few minor improvements necessary'. The audit made five recommendations; all of which the department was on course to complete by the end of 2016. These included ensuring non-Ramsay Health Care UK physiotherapists referring for imaging were appropriately authorised to do so; the setting of a diagnostic reference level for mobile X-ray facet joint injection procedures; a minor change in practice to reduce the dosage levels for barium swallow examinations; a check of fluoroscopy dose rates every two months; and encouragement of staff uptake of online training in radiation protection.

Good

Outpatients and diagnostic imaging

- The Ionising Radiation Regulations 1999 (IRR99) requires employers to keep employee exposure to ionising radiations as low as reasonably practicable and to ensure that exposures must not exceed specified dose limits.
- The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. These were displayed on the wall of the X-ray room. The rules were supported by the hospital's incidents greater than intended exposure of patients caused by procedural error policy. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor, who in turn logged the incident on the hospital's incident reporting system. The incident was then reported directly to the group's radiation protection advisers for dose calculation and where necessary to the medical physics expert. The rules and policy also set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive.
- In line with the IR(ME)R regulations, and the hospital's policy, a training record was kept for all non-medical referrers' scope of practice and entitlement to refer for imaging, which included referrals from the other co-located healthcare provider.
- All permanent staff had signed to confirm they had received up to date training and knowledge in line with the regulations. Although some bank radiographer staff had yet to sign, this was because the individuals involved had not since been on duty. The service lead told us these bank staff would be asked to sign when they were next on duty.
- The hospital had an examination of females of child bearing age policy, which included a pathway flowchart for staff to follow. Warning signs asking patients to tell staff if they may be pregnant were clearly displayed on doors into radiation controlled areas.
- A clinical radiology contrast agent and medicines for diagnostic imaging policy was in place. This included a treatment pathway that was based on the Royal College of Radiologists standards on the use of contrast agents.
- A pre and post checklist for radiological interventions was used in the hospital. The pre intervention check included confirmation by the patient of any known allergies or use of anticoagulant medication, the potential to be pregnant, or previous steroidal injections. For imaging staff, the pre intervention check included items such as checking ID, consent for the procedure, relevant medical history and confirmation of the marked site and compliance with IR(ME)R requirements.
- The pre and post intervention checklist was supplemented by the use of the World Health Organisation Surgical (WHO) Safety Checklist for Radiological Interventions. There was no information in the hospital's audit programme to indicate if compliance with the WHO checklist was audited.
- A two-way radio system was provided to staff of the other healthcare provider who operated the mobile CT/MRI unit. The radios were tested twice a day when the unit was on site. This aided communication between staff in the mobile unit and staff in the hospital department in the event of a patient deteriorating.
- A process was in place within the diagnostic imaging department for urgent review of images for unexpected findings or significant pathology. End of day reports, which highlighted any abnormal findings, were produced by staff in the mobile MRI/CT unit. These flagged potential issues that required urgent review and reporting by the on-duty radiologist. A check off system was used to record when these urgent requests had been completed.
- The diagnostic imaging department provided a seven day on-call mobile plain X-ray imaging service for urgent images of patients on the inpatient ward. These requests were subject to clear referral and safety criteria due to the risk of radiation exposure within the ward environment.

Nursing staffing

- Staffing levels were planned and reviewed using Ramsay Health Care UK's national electronic rostering management system, which embedded indicators for safety and effectiveness. This enabled heads of departments to manage rotas, shift allocations, annual leave and sick absences, skill mix and staff requirements including senior cover. The system provided indicators of safety and effectiveness and allowed heads of departments to manage shift allocation, annual leave and sickness absence.
- Staffing levels were reviewed on a daily basis to enable flexibility between the needs of patients and any unforeseen issues that arose. As of 1 April 2016, the outpatient department had 4.1 full-time equivalent

registered nursing staff and one full time equivalent health care assistant. No permanent nursing or healthcare assistant staff left in the 24 months between 1 July 2014 and 30 June 2016.

- There was no nursing staff sickness in the outpatient department between 1 July 2015 and 30June 2016. For eight of out twelve months in the same period there was no sickness for healthcare assistants. In the remaining four months, healthcare assistant sickness levels varied between 2.7% and 100%, however, this high variance likely reflect the small number of health care assistant staff in the department. There were no unfilled shifts reported in the three months between April and June 2016.
- Agency staff were not used in the outpatient department. The use of bank nursing staff (as a percentage of all staff in the department) varied between 21% and 35% in each of the twelve months between 1 July 2015 and 30 June 2016. The use of bank healthcare assistant staff varied between 35% and 91% for the same period.
- However, this usage of bank staff is likely to reflect the overall small numbers of permanent staff within the department and an increasing demand on the hospital's outpatient services.
- New staff members in the outpatient department were assigned a 'buddy' to provide support during the induction phase and met regularly with their manager to review performance progress against the induction programme.

Allied healthcare professionals staffing

- The diagnostic imaging department had three permanent radiographers and four administration staff. The diagnostic imaging manager and some admin staff were relatively new in post having been recruited within the last year as part of a department improvement plan.
- A bank of ten radiography staff were available to cover unfilled shifts, mainly in evenings and at the weekend. Bank staff were experienced within the department and had received up-to-date training, risk assessments and were within their documented scope of practice.
- The physiotherapy department had ten permanent physiotherapy staff. A bank of eight staff including qualified physiotherapists and physiotherapy assistants supported the team. Staff worked flexibly to meet the needs of the department.

Medical staffing

- In the period 1 July 2015 to 30 June 2016, the hospital had 94 doctors and dentists who were directly employed or were practicing under rules of privilege for more than six months. None had had practicing privileges suspended in the twelve months prior to August 2016.
- Staff in the outpatient, physiotherapy and diagnostic imaging departments were able to request the RMO to attend any patient who became ill in the department.

Emergency awareness and training

- Staff had received emergency fire training, and told us that the procedures for this were tested through simulation scenarios. Staff were aware of their responsibilities during a major incident. Contact details for staff to be used in an emergency were also held in another local Ramsay Health Care UK hospital. This meant that details were easily accessible in the event that staff at the hospital could not access the records.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective.

Evidence-based care and treatment

- Care and treatment was delivered in the department in line with legislation, standards and evidence based guidance, including from professional bodies and the National Institute for Health and Care Excellence (NICE).
- Patient clinical pathways were standardised. Pathway documents were used for each procedure, which included a specific outpatient procedure care pathway. These took into account guidance and established practice and included appropriate pre and post procedure checks and follow-up information.
- Diagnostic imaging procedures were carried out in line with established practices from the Royal College of Radiologists, the Ionising Radiation Medical Exposure Regulations [IR(ME)R] 2000 and the Ionising Radiations Regulations 1999.
- Physiotherapy treatment was provided in line with established practice and guidance from the Chartered

Society of Physiotherapy. Physiotherapy care and treatment was audited against the society's Quality Assurance Standards audit tool, with the department achieving 95% compliance in the safe service audit and 97% in learning and development. Physiotherapy equipment was risk assessed in line with the Provision and Use of Work Equipment Regulations 1998.

- All physiotherapy staff were registered with the Health Care Professionals Council (HCPC) and with the Chartered Society of Physiotherapists.

Pain relief

- Pain relief medication was not held in the outpatient department. Any pain relief medication would be prescribed to patients by consultants.
- The department had introduced a cross-site pain management clinic, mainly for musculoskeletal pain. The clinic, which ran every two weeks, was supported by the physiotherapy department and the consultant was able to refer directly into physiotherapy. Patients were screened using the Keele STarT Back tool (a simple prognostic questionnaire to identify modifiable risk for back pain disability) and those that required psychological input were referred to a local NHS acute hospital trust. As part of this, the department also introduced a hospital anxiety and depression tool.
- The physiotherapy department offered acupuncture therapy and shockwave therapy (mechanical pressure pulse treatment for tendon-related pain) for managing pain.

Patient outcomes

- Due to the nature of the services offered, patient clinical outcome data was not routinely collected by the hospital for the outpatient and diagnostic imaging department. The physiotherapy department monitored patient progress using a number of tools, including the Keele STarT Back tool, the Oxford Hip Score, the St George's Respiratory Questionnaire, a visual analogue pain scale and patient pathway discharge assessment tool.
- Although data from the discharge assessment tool was collated, it was not available to us in a format that enabled us to usefully analyse it. The remaining data from the other tools was used to understand individual patient progress, but was not separately collated.
- The patient satisfaction survey showed that 100% of those who responded experienced improvement in their condition.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. All new staff, including bank staff, were required to undertake an induction training programme, in line with the hospital's induction policy. The induction programme varied in length dependant on the staff member's role and competencies during which time the staff member met with their line manager at regular intervals to review their performance. One staff member we spoke with had been in post for six weeks and spoke positively about the induction process which the staff member felt was supportive. Another staff member told us new colleagues were assigned to a buddy during the induction phase.
- A competency framework was in place for existing staff and staff were expected to meet this. We viewed three nursing and three physiotherapy staff training files all of which included competency records, training and accreditation certificates.
- The hospital held records for all staff that had appropriate training to administer radiation. Competency records were also kept. These included competency to use each piece of equipment within the diagnostic imaging treatment rooms and the movement of equipment within the rooms. We reviewed the IR(ME)R procedures file within the diagnostic imaging department. The documentation held was up to date and included evidence that all staff had signed to confirm they had received training and had undertaken appropriate reading of the relevant procedures. Similarly, staff signed to confirm they had read the diagnostic imaging clinical policies.
- Staff within the diagnostic imaging department were registered with the Healthcare Professionals Council (HCPC) and Chartered Society of Physiotherapists. The physiotherapy manager was encouraging all staff to become accredited with the Acupuncture Association of Chartered Physiotherapists. The manager also delivered a yearly acupuncture course, which was open to all staff across the norther Ramsay Health Care UK hospital sites.
- One staff member in the diagnostic imaging department told us there was a 'very positive engaged approach to

[continual personal development which] is actively encouraged...' and that professional radiology journals were brought into the department for staff to read'. Staff were also given regular opportunities to review previous diagnostic imaging reports and apply these to the images, which assisted their learning.

- Staff appraisals were carried out yearly between January and December. By 1 November 2016, six out of nine (66%) outpatient staff had received an appraisal; two staff had not yet had an appraisal and the remaining staff member was receiving separate reviews following a departmental transfer. By the same date, all physiotherapy staff had received an appraisal.
- Staff we spoke with in all departments confirmed they had received appraisals this year. However, one staff member told us their previous appraisal had been approximately two years earlier.
- Due to the small size of the departments, regular formal one-to-one meetings were not scheduled with staff unless there were performance management concerns.

Multidisciplinary working

- Physiotherapy staff were encouraged to attend appropriate outpatient consultant appointments.
- The physiotherapy team leader worked closely with the orthopaedic and spinal consultants in the relevant clinics and with one consultant on pain management. One physiotherapist was a specialist in gynaecological problems, while another specialised in problems with hands. The team had a good working relationship with the diagnostic imaging department.
- The diagnostic imaging department were involved in multidisciplinary meetings with outpatient consultants to review imaging and reports. As a result, imaging reports were able to be refined, re-issued or relevant addendums added. The department also reviewed the hospital's external reporting agency's findings on the ten per cent double reporting sample of CT/MRI scan. Any concerns arising from this were fed directly to the medical advisory committee to consider if any changes in practice needed to be addressed.

Seven-day services

- The outpatient department offered a six day service, Monday to Friday between 8am and 9pm, and between 8am and 2pm on a Saturday. The department did not offer clinics on bank holidays.
- The physiotherapy department offered a six day outpatients service, Monday to Saturday between 8am and 5pm. Pilates classes were run each Tuesday and Thursday. Physiotherapy staff provided treatment to inpatients on bank holidays but not to outpatients.
- Diagnostic imaging was carried out Monday to Saturday. An on-call facility was in place for urgent X-ray imaging requests at night and the weekends.

Access to information

- Patient records were securely transported from the medical records office to the department each morning and afternoon. Although the hospital was aiming to introduce an electronic patient record system for full patient records, this was not yet implemented.
- Diagnostic images and records were electronic, which meant they were accessible to clinical and physiotherapy staff when needed. However, a known issue with the diagnostic image data supplier meant that older, historical images took longer to retrieve. Although this meant there was a risk that historical images may not be available for review in a timely manner, there was no indication of any incidences when this had impacted overall patient care.
- Physiotherapy staff told us of one incident where a patient's appointment was rescheduled as records were not available. This had occurred because of a late appointment booking where the patient's treatment was transferred from another Ramsay Health Care UK hospital in the region.
- Discharge letters were sent to each patient's GP within 24 hours following completion of treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a two-stage process to obtaining written consent for outpatient procedure care pathways. Stage one was carried out by the consultant in the outpatient clinic and included discussion of the benefits and risks of treatment. This meant that patients were able to make informed decisions about their treatment. The second stage of consent was carried out on the day of treatment and included confirmation that the risks of treatment had been discussed with the patient. Patients were given a copy of their signed consent.
- Verbal consent was obtained from patients undergoing physiotherapy. However, if there was any concern about

a patient's capacity to consent, staff rescheduled the appointment and requested assessment of the patient. Written consent was obtained from patients undergoing shockwave or acupuncture therapy.

- Flowcharts on mental capacity was displayed within the department. Staff were aware of the policies and processes, but told us the majority of patients they treated had capacity to consent to their care. Staff were empowered to be able to stop a consultation or treatment if they had any concerns about a patient's ability to consent to treatment. The patient would then be invited back to be assessed with family members in attendance. This was highlighted in an ophthalmic outpatient appointment, where the nurse had concerns about the patient's capacity to consent to treatment. The nurse subsequently carried out a mental capacity assessment checklist with the patient and their carer.
- A separate consent form (consent form four) was used for patients who did not have capacity to consent to their own treatment. This consent form included assessment of the patient's capacity to consent; assessment of the patient's best interests and reasons why treatment could not be delayed until the patient recovers capacity; and, involvement of the patient's carer, relatives or attorney in the discussions.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- People who used the outpatient, physiotherapy and diagnostic imaging departments were treated with kindness, dignity, respect and compassion when they received treatment at the hospital. One patient in the physiotherapy department told us 'the staff are brilliant. They are caring, very good, explain everything….absolutely wonderful'.
- The hospital recognised the important role that family and carers played in the care and treatment of patients who were living with dementia or learning disabilities. Relatives and carers were given a 'Working Together' leaflet and they were able to stay overnight in the hospital if necessary. They were given an 'I am a carer' card to present at the restaurant for a meal. The hospital also used the Alzheimer's Society's 'This is me' guide, which assisted staff to understand the personal preferences and needs of patients living with dementia in order to provide compassionate care.
- The outpatient department patient satisfaction survey, between January 2016 and September 2016, indicated an average of 99% of respondents reported they were treated with respect and dignity. Each outpatient consultation room was private, which meant that patients' privacy and dignity was maintained during outpatient appointments.
- The diagnostic imaging patient satisfaction survey showed that an average of 98% of respondents said that the team were friendly and reassuring during the examination. Although there was a potential risk to patient privacy and dignity due to the layout of the diagnostic imaging changing area, this was not reflected in the survey; 99% of respondents considered they had privacy whilst changing.
- The main reception area was at the entrance to the hospital and co-located with the main waiting patient waiting area. Staff were sensitive in conversations with patients, and were mainly involved with checking patients in for their procedures. We did not observe any confidential information being discussed at the reception desk.
- A chaperone service was available to patients, which was supported by the hospital's chaperone policy. Signs to remind patients of the chaperone service were clearly displayed in all consultation and treatment rooms. All nursing and healthcare assistant staff in the department were used as chaperones; however, only registered nurses acted as chaperones for gynaecology clinics. Patient records were updated to indicate that a chaperone was needed, or if there was a patient preference to have a non-female chaperone.
- The nature of the treatments provided within the outpatient, physiotherapy and diagnostic imaging departments meant that patients were, generally, not kept waiting within the department. However, where clinics ran late, staff offered drinks to patients. Staff were able to give food and drink for patients who were diabetic. A drinks vending machine was available in the reception waiting room and a snack vending machine was located near to the department.

Good

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- Staff in the outpatient, physiotherapy and diagnostic imaging departments communicated with people about their care and treatment in a way they could understand.
- The patient satisfaction survey between January and September 2016 showed an average of 97% of respondents said they were involved in decisions about their care in the outpatient department and were given enough time to discuss their health problems with a doctor.
- An average of 98% people indicated that doctors had explained the reasons for their treatment in a way they could understand. Ninety-two per cent of people said nurses had explained the treatment in a way they could understand; and 100% indicated staff explained test results in a way they could understand. Further, an average of 97% of respondents said they could understand the answers given by nurses to their questions. This was supported by the patients we spoke with, who told us staff had explained appropriate and relevant information and had provided contact numbers for any questions the patient may have.
- The physiotherapy patient satisfaction survey indicated that an average of 94% of respondents were satisfied with the advice on self-care and exercises provided to them during their treatment. However, 81% of respondents considered the written information they had been given was clear, easy to understand and helped them to make decisions about their treatment. The department was, in conjunction with the outpatient department, working to produce a combined patient information leaflets which include details such as physiotherapy exercises to be undertaken. This has been successfully trialled for an information leaflet related to arthroscopy treatment.
- The patient satisfaction survey also showed that 100% of respondents were satisfied that physiotherapy staff had taking into account any special needs such as hearing, sight and language. Ninety-four per cent of respondents felt they understood the role of the physiotherapist treating them and 90% said they felt they were listened to when asking questions.
- One physiotherapy patient told us they had attended the department for four separate appointments, during which staff explained everything to the patient. The patient said they were given contact numbers for the department if they had any questions. The patient said 'staff were brilliant' and that the care provided was 'absolutely wonderful'.
- In the diagnostic imaging department, an average of 98% of respondents said that information given to them about the examination was useful. However, an average of 81% said they were told how to get results of their examination. Following a related complaint, the department recognised there had been a risk of communication breakdown with patients about whether or not a follow-up appointment would be needed to be given the results. The department introduced a simple pro-forma slip to be given to patients after their examination. This provided information about whether or not a follow-up appointment was needed for results and prompted the patient to make this with the bookings team.
- One nursing staff member told us they started work early to be able to accommodate the needs of one patient who required an earlier appointment slot due to the needs of the patient's business.

Emotional support

- Individual consultation rooms in the outpatient department meant that privacy was maintained for patients.
- The diagnostic imaging department informed staff in the outpatient department if there would be bad news for a patient. As such, staff tried to schedule appointments for patient receiving bad news towards the end of the clinic day. This enabled extra time for the patient to ask questions or to reflect on their news. The outpatient department's manager told us that despite the physical limitations of the department, staff would try to find an available room for a patient and their relatives if they wished after their consultation.
- There were sufficient numbers of nursing and healthcare assistant staff on duty to be able to provide additional emotional support to patients, if needed, without affecting delivery of the service.
- The outpatient department were able to offer tours of the relevant areas of the hospital to patients living with learning disabilities prior to their treatment. This helped to reduce any anxiety the patient may have.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital was, except for staff offices, a single storey building. The main entrance was by the car park. The reception area was bright, clean and tidy. The open plan waiting area for patients was in the reception area. Toilet facilities, which included disabled access, were located off the main reception area and a range of patient information leaflets were available. There was no separate waiting area for outpatients, who remained in reception until called.
- Late clinics provided flexibility for patients and additional clinics were scheduled where possible to meet demand. Saturday morning clinics were offered in the outpatient department and physiotherapy department added two additional evening classes and a Saturday morning clinic to help reduce waiting times. The physiotherapy department also supported orthopaedic inpatients.
- There was clear signage throughout the hospital to guide patients to the appropriate department.
- Public transport to the hospital was adequate and free car parking was available on-site. However, at peak times there were not enough parking spaces, which meant that patients and visitors parked on the road. Car parking facilities were being considered as part of the hospital development plans, including further encouragement for staff to park away from the site.

Access and flow

- There were 30,927 outpatient, physiotherapy and diagnostic imaging attendances to the hospital between July 2015 and June 2016 of which 80% were NHS funded. The remaining patients were self-paying or insured.
- NHS referrals into the departments were from GPs, consultants and through the NHS choose and book appointment system.
- Between July 2015 and June 2016, an average of 99.5% of NHS non-admitted patients started outpatient treatment within 18weeks of referral against the target of 95%. In the same period, 99% of patients who had not yet completed their treatment had commenced treatment within 18 weeks of referral. This was better than the hospital's target of 92%.
- Between July 2015 and June 2016, no NHS patients waited longer than the six-week target for a CT scan. For MRI scans one patient (out of 80, 1.3%) in July 2015 and three patients (out of 121; 2.5%) in March 2016 waited longer than six weeks. For non-obstetric ultrasound scans, one patient (out of 131; 0.8%) in July 2015 and one patient (out of 60; 1.7%) in January 2016 waited longer than six weeks.
- All available consultation and treatment rooms were fully utilised and with increased demand, physical capacity within the department was an issue recognised by hospital management. Future development plans for the hospital included increasing the physical capacity of the department.
- The physical limitations of the department meant there was limited ability to absorb delays in clinics that were running late. The outpatient manager discussed any late running clinics with the relevant consultant and a process was in place to take these forward to the senior management team if necessary. Waiting patients were informed by staff if clinics were running late, and when appropriate, additional refreshments were provided. The hospital did not keep a record of clinic cancellations; however, consultant staff were expected to provide six weeks' notice of any periods of leave and clinic cancellations. The outpatient manager told us that, in the event of a cancellation, a new appointment was made with the patient before they left the department.
- The outpatient and diagnostic imaging department's rostered staff to take account of overrunning clinics or theatre lists. Physiotherapy staff managed their own clinics, which meant that clinics generally ran to time. Although the physiotherapy department aimed for a four week wait for treatment for new NHS patients at the time of our visit, staff were booking new patients for January 2017 (an approximate nine week wait). The physiotherapy department had recently implemented

two additional evening classes and an extra Saturday morning clinic to address the waiting time delay; however, it was too early to identify the impact on the waiting list.
- The hospital did not collect data relating to clinic delays. However, the physiotherapy department told us a process was in place for the discharge of patients, at the physiotherapist's discretion, following two consecutive missed appointments.
- The diagnostic imaging department reported plain X-ray films internally. At the time of our visit, there was an approximate two week delay in reporting of these images because of the half-term holidays. The diagnostic imaging manager expected this to be resolved once staff returned from leave.

Meeting people's individual needs

- Entrances to the hospital were accessible to wheelchairs, with automatically opening doors. All departments were located on the ground floor of the hospital. Accessible toilets for patients living with a disability were located behind the reception area and within the departments. Refreshments, including water, tea, and coffee were available from a vending machine in the waiting area at a small cost to NHS patients; other funded patients were given a token for refreshments.
- In the diagnostic imaging department a small changing and waiting area was situated next to the X-ray room. The changing area consisted of two small cubicles, separated by only a curtain, with a chair and a small lockable cupboard in each for patient property. Patients who had changed then needed to walk past others in the waiting area in order to access the X-ray room. This meant there was a risk that patient privacy and dignity could be compromised.
- Staff were aware this was an issue and told us it had been raised for inclusion in the future development plans in the hospital. In the meantime, staff told us they kept patients in their own clothes as far as possible to reduce the number of instances where patients needed to change. Staff also told us they would not ask two patients to use the changing area at the same time and they would escort patients from the changing area to the X-ray room to help ensure patient dignity was maintained.
- The physiotherapy department included one individual treatment room and an open plan area with three treatment bays separated by privacy curtains and a small rehabilitation area including gym equipment.
- The physiotherapy department had a small waiting area, which included a toilet for patients. However, as there was no separate door between the waiting area and the treatment area, there was a risk that patients waiting for treatment could overhear conversations within the treatment area particularly at busy times when noise levels in the department increased. Staff were also aware this was an issue and again it had been raised for inclusion in the future development plans for the physiotherapy department.
- Translation services were available for patients whose first language was not English. Staff were also able to access British Sign Language interpreters if needed.
- Patient information leaflets were readily available in the waiting area and in all the departments. Although the majority of leaflets displayed in the departments were in English, staff were able to download leaflets in other languages if needed. Easy read leaflets were available for patients who were living with learning disabilities.
- The patient leaflets clearly explained the patient's condition and treatment and were provided during consultations. This meant patients were able to consider their options at home before making any decisions to proceed.
- A signature guide was used to assist patients with poor vision when signing documents including consent forms.
- The hospital reported they did not see large numbers of patients with learning disabilities or people living with dementia. However, staff also received training on people living with dementia and had attended a talk from the Alzheimer's Society as part of the hospital's equality and diversity Commissioning for Quality and Innovation (CQUIN) programme. Information about dementia was shared in hospital newsletters. One of the physiotherapists had been trained as a dementia friendly champion. Reception staff alerted the departments when a patient, known to have dementia, arrived.

Learning from complaints and concerns

- The hospital recognised there had been an increase in the number of complaints about the diagnostic imaging department because of staffing and responsiveness

issues that the department had experienced in the latter months of 2015. However, the Matron supported the diagnostic imaging team throughout the implementation of the department's improvement plan. The number of complaints received about the department reduced following the recruitment of the new departmental manager

- In line with the hospital's complaints policy, the hospital acknowledged complaints relating to the department within two working days enclosing a copy of the complaints procedure information leaflet. We reviewed two complaint files within the diagnostic imaging department. Both demonstrated robust complaint investigation and included appropriate responses within the complaint policy's 20 working day timescale. One of the complaints resulted in the introduction of a follow-up slip to advise patients on whether or not they required a follow-up appointment.
- The diagnostic imaging department had, as a result of a patient complaint, introduced a communication slip which ensured that patients were aware if they needed to be seen again in a follow-up clinic to obtain results.
- Staff in the physiotherapy department told us that, as a result of a patient complaint, they had redesigned the arthroscopy patient leaflet. This meant that information from both the outpatient and the physiotherapy department was included in the leaflet and prevented the patient receiving conflicting information. The department was aiming to roll this out for other conditions and procedures.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The hospital manager was supported by the matron and the physiotherapy, outpatient and diagnostic imaging departmental managers. Although the physiotherapy and outpatient managers had been in post for some time, the diagnostic imaging manager had been recruited earlier in 2016.
- Staff in all departments spoke positively about the senior management team, the Matron, and their line managers. Staff said that the senior management team were visible within the hospital but there was less visibility or recognition or corporate staff. However, this was not unanimous; two staff members expressed reservations about the leadership styles of two managers.
- One staff member told us 'since matron has been on board we have been a lot more supported'. The same staff member said that senior management were 'very approachable' with an 'open door policy'. This was reflected by a member of reception staff who told us the hospital manager was 'approachable'. Another staff member who had worked on the bank before becoming permanent, spoke very positively about the department manager, and told us they felt 'more valued and involved in the department than ever before'. Other comments made by staff included: 'second family for me', 'feel supported', 'lovely place to work', and 'I love interacting with patients'. However, staff also reflected concerns about the physical capacity of the hospital in light of increasing demand for the hospital's services.
- The Matron held monthly one-to-one meetings with the departmental managers and attended departmental team meetings bi-monthly.

Vision and strategy for this this core service

- The diagnostic imaging department faced a number of performance and governance issues in 2015, which had been recognised by the hospital. A development and improvement action plan was implemented in January 2016. The action plan, driven by the matron and the new diagnostic imaging manager, covered areas such a compliance with IR(ME)R and radiation protection regulations, medicines management, cleanliness and infection prevention and control, training, medical emergency response, reporting and documentation, and patient communication. The majority of actions had been completed by 30 July 2016. The two outstanding actions related to collation of bank staff training records and the replacement of chairs in the X-ray room and waiting area.
- Although there was no separate strategy for the outpatient department, staff were aware of 'The Northern Blitz' strategy and the visual representation of the plan was displayed in the departmental offices.

Governance, risk management and quality measurement

Good

Outpatients and diagnostic imaging

- Although there was a governance framework in the hospital, which supported the delivery of good quality care in the department, the hospital's risk register did not include any open outpatient, physiotherapy or diagnostic imaging departmental specific risks on the register, nor did it indicate any mitigation or control factors for risks that had been included.
- Further there were no separate risk registers held in the individual departments. When asked about this, staff referred us to the schedule of risk assessments. Although the list of risk assessments was comprehensive for the physiotherapy and diagnostic imaging departments, we could not be assured that risks affecting the day to day running of each of the departments, or the services they offered, had been identified; for example capacity and staffing issues.
- As part of the wider corporate organisation, the hospital had a clear governance and committee structure in place including clinical governance, medical advisory, health and safety, head of department, blood transfusion and infection prevention and control committees. The governance structure was supported by detailed policies and procedures.
- Staff were clear about their roles, how they fitted within the hospital structure, and who held the relevant lines of reporting responsibility.
- Team meetings were held in each of the departments, which shared learning and updates to policies and procedures.
- The diagnostic imaging manager recognised that audits had not always been completed in the department in 2015 due to performance issues within the department. However, since starting in post, the manager had re-implemented the audit programme. The results of audits were discussed at the various committees..

Public and staff engagement

- NHS Friends and Family test scores between July 2015 and June 2016 demonstrated an average of 98% of a total of 1858 NHS funded respondents were likely or extremely likely to recommend the hospital's outpatient department. One patient commented in the survey 'I have used Fulwood Hall on a number of occasions in the past and have always been extremely satisfied with its courtesies and treatments that I have received. This is why I have chosen the hospital for this treatment and why I have already recommended family and friends to use Fulwood Hall'.
- However, the Friends and Family test response rates for the outpatient department were very low at an average of 4.3% for the same period and did not meet the hospital's target of 10% response rate.
- The hospital took part in the Ramsay Health Care UK customer service excellence awards scheme. Two staff in the physiotherapy department had received awards and a staff member in the outpatient department had two nominations. One staff member told us the award scheme meant that staff 'feel appreciated'.

Innovation, improvement and sustainability

- The hospital had drawn up development plans to increase physical capacity throughout the hospital. The plans included increasing the capacity in the outpatient and diagnostic imaging departments, improvement of equipment and facilities and consideration of re-siting the physiotherapy department.
- The physiotherapy manager was considering the development of outreach clinics in local gyms and leisure centres. It was also hoped to move towards full electronic patient records for the physiotherapy department.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had a robust system for awareness, training and monitoring safeguarding adults at risk of abuse or neglect, and safeguarding children and young persons. Policies and procedures were comprehensive. There were four safeguarding leads and training was delivered to all staff. Additional safeguarding sessions were delivered monthly. Staff gave us examples of when safeguarding issues had been identified and led to changes within the hospital.
- All staff worked hard to ensure that patients were treated with kindness, dignity and respect. This was reflected in both monthly Friends and Family audits and in the comments and reflections of patients at the time of the inspection. Many examples were given of patient experiences and changes to process and procedures as a response to feedback.
- The hospital had excellent referral to treatment times for both outpatient and diagnostic services and surgical treatments. Between July 2015 and June 2016, an average of 99.5% of non-admitted patients started outpatient treatment within 18 weeks of referral against the target of 95%. In the same period, 99% of patients who had not yet completed their treatment had commenced treatment within 18 weeks of referral. This exceeded the hospital's target of 92%.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all housekeeping records of weekly water outlet checks are accurate, up to date and maintained.
- The provider should consider the most appropriate environment is available for conducting pre- operative assessment appointments, in order to protect patient dignity and confidentiality.
- Staff should ensure records trolleys are kept locked when not in use.
- The hospital should consider how it can ensure completion of mandatory training by bank staff in theatre and the ward in a timely manner.
- The hospital should consider how it can measure clinical effectiveness of patient care and treatment in the outpatients department.
- The hospital should consider how it can prevent recurring deficiencies in the consent process identified within the consent audit.
- The hospital should consider how it can ensure the timely reporting of plain film X-rays during high periods of leave, such as school holidays.
- The hospital should consider how it could track and analyse data relating to the late running of clinics, clinic cancellations and patients who did not attend appointments within the departments.
- The hospital should consider how it can address the low percentage of staff recruited from a black and minority ethnic background.
- The hospital should consider how it can improve the identification of risks to the operation of the departments and services offered and the logging of these on departmental and hospital risk registers.
- The provider should ensure that risks to patients are identified, assessed and monitored consistently, and that action plans are updated and contain enough detail to enable staff to reduce those risks effectively.