Fairfield Independent Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Fairfield Independent Hospital is a charitable, non-profit making organisation based in St Helens, Merseyside and is part of the Guy Memorial Home Limited.

Fairfield Independent Hospital is registered to provide the following Regulated Activities:

• Diagnostic and screening procedures.

• Surgical procedures.

• Treatment of disease, disorder or injury.

The hospital's senior management team consists of the Board of Trustees, the Chief Executive, and a team of hospital managers.

We inspected the hospital on 26 and 27 July 2016 on an announced visit. On 10 August 2016, we carried out an unannounced inspection of the hospital.

We inspected all services that were provided by Fairfield Independent Hospital. Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections.

Additionally, there are services provided by other registered organisations at the hospital which we did not inspect as part of this inspection. However, we looked at the service level agreements that were in place for these and how these were being managed.

We rated Fairfield Independent Hospital as 'Good' overall. We rated both surgery and outpatients and diagnostics as good in safe, effective, caring, responsive and well-led. However, this excluded effective in outpatients and diagnostics as we do not currently rate this.

Are services safe at this hospital

We rated safety as 'good' in both surgery and outpatients and diagnostic imaging because;

- The hospital had systems in place to manage risk. This included policies describing how to measure and escalate risk as well as reporting incidents. Staff that we spoke to understood how to use the paper based system and were able to give us examples of incidents that they would report. Staff told us that when they had reported incidents they had received feedback from these.
- The hospital had appropriate infection prevention and control procedures in place. There had been no reported incidents of hospital acquired infections between April 2015 and March 2016.
- We found that there were sufficient numbers of appropriately skilled staff to care for patients that were receiving care and treatment. A nursing acuity tool had been used to calculate the current staffing establishment and a weekly planning meeting was held to calculate how many staff were required. We observed staff handovers and found that they were robust and provided continuity of care for patients.
- Staff in theatre followed the 'five steps to safer surgery' and on most occasions the 'WHO' checklist was followed and completed appropriately.
- There were safeguarding policies and procedures in place to keep patients safe. There was a designated safeguarding lead and there were appropriate numbers of staff trained in safeguarding. Staff we spoke to were able to give us examples of what would constitute a safeguarding referral to be made.

Summary of findings

- Patient care was consultant-led and there was 24 hour cover provided by a resident medical officer who was based on site.

Are services effective at this hospital

We inspected but did not rate effective in outpatients and diagnostic imaging. We rated effective as 'good' in surgery because;

- The hospital provided care and treatment in line with up to date evidence based practice. We checked a sample of clinical guidelines and found them to be appropriately referenced against up to date guidance on most occasions.
- Patient outcomes were regularly monitored through compliance with key performance indicators and regular data submissions were provided for benchmarking. Records indicated that patient outcomes were similar to other services nationally.
- Local audits were also completed on a regular basis so that performance and compliance in certain areas were monitored and improved when required.
- There were systems in place to check the competencies of consultants who had applied to work under practicing privileges at the hospital. This process involved any application being agreed by the medical advisory committee.
- Staff received a yearly appraisal in line with the hospital policy.
- The hospital had policies and procedures in place for consent, mental capacity and deprivation of liberty. Consent was sought prior to any treatment and patients were required to sign consent forms, which were then confirmed on the day that patients attended the hospital.

Are services caring at this hospital

We rated caring as 'good' in both surgery and outpatients and diagnostic imaging because;

- Staff were caring, compassionate and treated patients with dignity and respect.
- Patients' privacy and dignity were maintained while receiving care and treatment.
- Results from the NHS friends and family test were positive with most patients saying that they would recommend the hospital as a place of treatment.
- Staff ensured that patients were involved in how their care was delivered.

Are services responsive at this hospital

We rated responsive as 'good' in both surgery and outpatients and diagnostic imaging because;

- National targets for access to outpatient and diagnostic services had been met consistently between April 2015 and March 2016. Additionally, the hospital aimed to see 90% of patients within 30 minutes of arrival. This target had been exceeded between January 2016 and June 2016.
- Referral to treatment times for surgery between April 2015 and March 2016 had also been consistently met.
- Services were mostly delivered in a way that met the needs of patients who attended the hospital.
- A dementia strategy was used to support patients living with dementia. Some hospital facilities had been adapted to meet the needs of patients living with dementia and the hospital ensured that appropriate support was provided when needed.
- The hospital had a clear admissions policy which meant that they were able to exclude patients who they were not able to provide care and treatment for.

Summary of findings

- The hospital had a complaints policy that was followed if concerns were raised. Information was available for patients and relatives describing the complaints process. This also included information about who to contact if it was felt that the response was unsatisfactory.

Are services well-led at this hospital

We rated well-led as 'good' in both surgery and outpatients and diagnostic imaging because;

- The hospital had a strategic plan from 2015 to 2020. This plan included a mission and a vision for the hospital.
- Areas for further improvements that the hospital could make had been identified and the management team reviewed this on a regular basis.
- Care and treatment provided was monitored so that gaps were identified and improvements could be made.
- The hospital used a risk management policy and system that identified and scored risks for both outpatient and diagnostics as well as surgery. We found that this process had been followed on most occasions. There were designated members of the management team who had responsibility for managing this.
- There was a governance structure in place that allowed information to be fed up to the appropriate members of the management team. Any concerns, incidents or policies and guidelines waiting for approval were discussed as part of the medical advisory committee meetings.
- Fit and proper persons legislation was taken into consideration when recruiting to the management team or the board of trustees. This included conflict of interests, financial background checks and disclosure and barring service (DBS) checks.
- There was a positive culture within the hospital. Staff that we spoke to were proud to work in the hospital and felt that a good standard of patient care was delivered.
- Leaders were visible throughout the hospital and staff felt well supported.

However, there were also areas of where the provider needs to make improvements.

The provider should:

- The hospital should take action to address that not all staff are aware of the policy with regards to female genital mutilation (FGM). FGM should form part of the adult safeguarding policy and not just the children's safeguarding policy.
- The hospital should take action to ensure all consent forms are fully completed.
- The hospital should take action to provide leaflets to patients that are regularly reviewed, and in date with the latest information.
- Risk assessments should be scored appropriately and where necessary escalated to the senior team.
- Risk assessments for the department should be reviewed to ensure that all areas of the service are considered so that risks can be mitigated, and actions put in place to reduce the impact and severity.
- The hospital should consider patients privacy on booking in to the department as there was no privacy line.
- The hospital should consider providing seating for those patients with mobility difficulties.
- The management team should make sure that all consultants sign to confirm final site marking verification during the 'sign in' phase of the WHO checklist.

Summary of findings

- The hospital is in the process of becoming JAG accredited for endoscopy services and this is planned for May 2017. The hospital should ensure that the implementation plan is achieved.
- The hospital should ensure that all mandatory training for staff is completed in a timely manner and meets the hospital compliance target as a minimum.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Patients using the services were protected from avoidable harm and the hospital had safe systems and good practices in place. We found processes in place to reduce the risk of abuse and avoidable harm in the hospital's inpatient and theatre teams. Information received from the provider prior to our inspection confirmed that training was provided to staff, relating to both vulnerable adult and child safeguarding. The staff we interviewed at our inspection confirmed this. Systems were in place to report and record concerns about patients who were treated. The staffing levels in both inpatient services and theatres were sufficient to meet the needs of patients and there was access to medical support at all times.
Outpatients and diagnostic imaging	Good	Policies and procedures were in place for the prevention and control of infection and to keep people safe. Care provided was evidence based and followed national guidance. Quality and performance were monitored and patients' views were actively sought. Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. Patients had a choice of appointments available to them through the 'choose and book' service.

Summary of findings

Contents

Good

Fairfield Independent Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Fairfield Independent Hospital

The hospital first opened its doors in 1974 as a home for the elderly. In 1975 the hospital opened with one operating theatre and twenty beds and became more focussed on surgery and outpatient treatment. Following a very successful fundraising appeal in 1977 work started on building an extension to provide more operating theatres, outpatient facilities and more bed rooms.

Outpatient and inpatient services are provided to patients of 16 years of age and above. The majority of treatment provided is done through a contract with the NHS. In addition, private treatment is also provided.

The hospital is located in a rural setting in St Helens. It has good transport links to both Liverpool and Manchester and is easily accessible via the motorway network. The hospital is set in landscaped gardens and there is free car parking.

The registered manager of the hospital is Cheryl Nolan, Chief Executive Officer who has been in post for eight years.

We inspected all services that were provided by Fairfield Independent Hospital. Our inspection was part of our on going programme of comprehensive Independent Health Care inspections.

Additionally, there are services provided by other registered organisations at the hospital which we did not inspect as part of this inspection. However, we looked at the service level agreements that were in place for these and how these were being managed.

Our inspection team

The team included an inspection lead, two CQC inspectors, an inspection manager, a clinical nurse specialist, a ward manager, a nurse clinician and a chief executive.

How we carried out this inspection

We carried out the inspection by asking the following five questions which we ask of every provider;

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

Before and after our inspection, we reviewed information about the hospital and each core service.

We carried out an announced inspection between 26 and 27 July 2016 and an unannounced inspection on 10 August 2016. We spoke to members of staff of all grades, including consultants and the resident medical officer who were not directly employed by the hospital as well as patients and relatives who use the hospital services. We visited all clinical areas and observed direct patient care and treatment. We also reviewed a sample of patient records and looked how medicines were managed.

We also interviewed the hospital's senior managers, including the registered manager, chief nurse and chair of the medical advisory committee.

Summary of this inspection

Information about Fairfield Independent Hospital

The hospital provides a wide range of services including both medical and surgical specialties. The specialties treated at Fairfield are as follows: Cardiology, Dermatology, ENT, Endocrinology (Diabetes), Haematology, General Surgery, Gynaecology, Ophthalmology, Oncology, Plastics, Respiratory Medicine, Orthopaedics, Maxillofacial, Rheumatology, Gastroenterology, Neurology, Urology, Psychology, and Psychiatry. The hospital has a full range of diagnostic facilities including plain, fluoroscopy, ultrasound and mammography imaging. MRI and CT scanning is provided by mobiles who visit regularly. The hospital also uses a Class 4 Fractional CO2 Laser to treat skin and burn complaints.

Hospital activity between April 2015 and March 2016 was as follows;

- 5,142 visits to theatre.
- 4,165 day case attendances.
- 969 inpatient attendances.

Additionally, for outpatient activity there were;

- 12,027 first attendances.
- 35,320 follow up attendances.

75% of inpatient and 70% of outpatient attendances were funded by the NHS. Other attendances were funded privately.

Fairfield Independent Hospital has a number of contracts with local care commissioning groups and are responsible for providing evidence that the agreed standards are being met. This is done through a number of key performance indicators and regular engagement.

The accountable officer for controlled drugs is Julie Ollerton, Chief Nurse.

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

Information about the service

Fairfield Independent Hospital provides elective surgery to NHS and private patients within the following specialities; ENT, General Surgery, Haematology (symptom control only). Gynaecology. Ophthalmology, Plastics. Orthopaedics. Endoscopy, Neurology, Urology, and Maxillofacial.

There are 32 single rooms with en-suite facilities in the hospital, which cater for patients post operatively.

The hospital has two operating theatres and a laser theatre for Endovenous Laser Ablation, (EVLA) procedures; immediate post-operative recovery bays and a six bedded 2nd stage recovery unit. The hospital provides an on-site decontamination facility.

There were 5,142 inpatient and day care episodes recorded at the hospital in the reporting period (Apr 2015 to Mar 2016); of these 75% were NHS funded and 25% were funded through other sources.

The hospital caters for short stay patients who generally attend on a day-care basis or overnight. Fairfield had approximately 16% of all its NHS funded patients and 28% of all its other funded patients staying overnight at the hospital during the same reporting period.

During our inspection we visited all areas providing surgical services, the in-patient ward, day care ward, theatres and recovery areas.

In terms of staffing, theatre and inpatient personnel equate to 43 of the full time staff in the hospital.

In the course of the inspection we interviewed 11 staff including managers, nurses, Healthcare assistants and consultants and spoke to five patients who were being treated by the hospital.

We reviewed the patient's environment, observed patients' care and looked at six full sets of patients' records.

Before and during our inspection we reviewed the provider's performance and quality information.

Good

Surgery

Summary of findings

We rated this service as good because;

- Patients using the services were protected from avoidable harm and the hospital had safe systems and good practices in place.
- We found processes in place to reduce the risk of abuse and avoidable harm in the hospital's inpatient and theatre teams. Information received from the provider prior to our inspection confirmed that training was provided to staff, relating to both vulnerable adult and child safeguarding. The staff we interviewed at our inspection confirmed this. Systems were in place to report and record concerns about patients who were treated.
- All clinical and ward areas were visibly clean, well equipped and infection prevention and control practices were in place to reduce the risk of infection.
- Staff told us that their services were safe and took pride in their own professionalism and ability to make decisions about risk. Patients we spoke with confirmed this, telling us they also felt safe whilst in the care of the hospital staff.
- Patient's individual risks were assessed to ensure only those suitable received treatment at the hospital.
- Inpatient and theatre ward staff mandatory training figures showed high levels of compliance, in June 2016 they were just above the hospital target of 90%.
- The staffing levels in both inpatient services and theatres were sufficient to meet the needs of patients and there was access to medical support at all times.
- During our interviews with staff teams, staff told us that they generally felt that they did make a difference in people's lives and they saw themselves as effective in their jobs. Patients confirmed this and told us that staff were effective.
- We observed staff showing empathy and concern for people they treated. We saw that staff were caring and compassionate and treated patients with dignity and respect.
- Patients told us they felt informed about their treatment and had been actively involved in decisions about their care, which included choices about date of surgery/procedures.
- Services were planned to meet patient needs including two admission slots on the day of surgery. The hospital were also flexible on choice of date for admission and time of surgery procedure.
- There was an effective process for managing and learning from complaints and compliments.
- Managers were visible in services and showed leadership. The staff told us managers were available and supportive, often coming into services areas to see how staff were coping.
- Governance systems were in place to manage risk effectively and staff understood and adhered to governance processes.

However,

- We found two sets of patient notes in which consultants had not signed to confirm surgical site markings for patients who were going into surgery. Surgical site marking is a vital part of the pre-operative process. Patient's surgery areas are marked to verify where surgery should be conducted to prevent wrong sites being operated on. Whilst the theatre staff had placed other checks and balances to ensure wrongful surgery did not occur, surgeons should sign to confirm final verification during the "sign in" of the World Health Organisation Safer Surgery [WHO] checklist.
- We found registered nurses were below the providers training compliance levels of 90% in three areas.
- We looked at 14 prescription charts and found there was no clear procedure in place for medicines reconciliation. Two of the 14 prescription charts we looked at did not list all the patients' current medicines.
- Whilst surgery times for patients were staggered throughout the day; we found that at times stagger times became congested and this led to some individuals having to wait longer than expected to enter surgery.

Good

Surgery

Are surgery services safe?

Good

We rated safe as 'good' for surgery. This was because;

- The hospital collected data which informed a Safety Thermometer. The thermometer provides the hospital with a 'temperature check' on harm that can be used to measure its progress in providing harm free care for its patients.
- The hospital had a clear and transparent incidents reported system and a culture where staff felt they could raise incidents when required.
- The hospital had a clear safeguarding reporting system and staff were able to describe safeguarding concerns which they would report.
- There were no incidents categorised as severe reported in theatre or inpatient departments at the hospital in the period July 2015 to July 2016.
- We found good infection control processes in place.
- We found low rates of infections following surgery, when we compared it to other independent acute hospitals we hold data for.
- The hospital wards and theatre areas were visibly clean and well furnished.
- Patients were risk assessed to ensure only those suitable received treatment at the hospital and risks were reviewed and actions updated during the patients stay.
- Medicines were well managed through policies and staff understood how to follow medicine procedures.
- The hospital had a policy on escalation if patients needed to be transferred to an acute hospital. We found staff were aware of the processes to follow in the event of an emergency.
- The patient records we reviewed were clear and concise.
- Equipment in the theatres and wards was well maintained by the use of a maintenance log.
- Surgical equipment was sterilised effectively and monitored by clinical staff.
- Staff were aware of the Duty of Candour legislation and we saw evidence of Duty of Candour letters sent on behalf of clinicians.
- Staffing levels across theatres and wards were sufficient to meet the needs of patients and we found good access to medical support at all times.
- Medicines were safely stored and handled correctly.
- There were good levels of mandatory training across the two staff groups.

However,

- We found two sets of patient notes in which consultants had not signed to confirm surgical site markings for patients who were going into surgery. Surgical site marking is a vital part of the pre-operative process. Patient's surgery areas are marked to verify where surgery should be conducted to prevent wrong sites being operated on. Whilst the theatre staff had placed other checks and balances to ensure wrongful surgery did not occur, surgeons should sign to confirm final verification during the "sign in" of the World Health Organisation Safer Surgery [WHO] checklist.
- We looked at 14 prescription charts and found there was no clear procedure in place for medicines reconciliation. Two of the 14 prescription charts we looked at did not list all the patients' current medicines.

Incidents

- Incidents at Fairfield Independent Hospital were reported via a paper based reporting system. The staff were aware of how to report incidents using the system.
- The staff group were clear on the types of things that would be deemed as an incident.
- The hospital had a clear and transparent Incident reporting system and an open culture where staff told us they felt they could raise incidents when required.
- Staff told us that managers took incidents seriously and put systems in place to prevent them occurring again.
- The staff received feedback on any issues which arose through team meetings and safety huddles. Patient safety huddles are daily focused team discussions which primarily focus on any risks or concerns about patients.

Good

Surgery

- Fairfield collected data which informed a Safety Thermometer. The thermometer provides the hospital with a 'temperature check' on harm that can be used to measure its progress in providing harm free care for its patients.
- Between April 2015 and March 2016, there were no incidents categorised as severe harm, reported in the theatre or inpatient departments at the hospital.
- We saw evidence that the hospital had an incident log where serious incidents were investigated and we were able to see learning from incidents which was shared across theatre and inpatient departments.
- We were told by Heads of Department that they discussed lessons learnt from incidents with their staff. The staff in their respective teams confirmed this when we spoke to them.
- From April 2015 to March 2016 there had been no incidents of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium difficile (C.diff), or Escherichia coli (E.coli).
- There had been no deaths or serious injuries recorded by the service between April 2015 to March 2016.
- Data provided by the hospital showed that between April 2015 to March 2016 there were 35 incidents recorded in surgery and inpatients with the majority being categorised as causing low or minor harm.
- The theatres and inpatient departments recorded no never events in the last 12 months.
- 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. The staff in both theatre and inpatient wards were aware of the Duty of Candour legislation. The staff we spoke with, were clear when the legislation applied and why it was important. We saw evidence of a Duty of Candour letter which was written on behalf of the hospital and one of its clinicians.

Cleanliness, infection control and hygiene

- All areas in both wards and theatres were visibly clean and well maintained.
- Records we reviewed both prior and during inspection confirmed that there had been low numbers of infection rates following surgery. From April 2015 to March 2016 we found the hospital had only ten minor surgical infections occurring after 5142 surgical procedures.
- Patients in the hospital were screened, assessed and tested at the pre-operative stage for methicillin-resistant Staphylococcus aureus (MRSA), a type of bacterial infection that is resistant to a number of widely used antibiotics. If a patient was identified as having MRSA their surgery was postponed while treatment to eradicate the MRSA was completed.
- From April 2015 to March 2016 there had been no incidents of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium difficile (C.diff), or Escherichia coli (E.coli).
- Hand disinfectant gel was available at the entrance to all ward areas and theatres and we saw staff using it as they accessed clinical areas i.e. the theatres.
- We saw staff in wards adhered to the 'bare below the elbows' policy when providing care and treatment.
- We saw evidence that the hospital had a theatre sterile service process for endoscopy. The procedure covers a washer area cleaning procedure and an endoscopy decontamination procedure.
- Records we reviewed confirmed that policies and procedures for the prevention and control of infection were in place and up to date.
- Records we reviewed confirmed that the hospital had an infection control plan for 2016/2017. The document was developed to provide a training schedule in infection control across services and ensure the latest guidance was followed.
- There was an Infection Prevention and Control team with designated leads across the hospital, which supported infection control link staff from each department. The teams remit included; completing monthly audits, completing hand hygiene audit, attending at the monthly Infection Prevention and Control Group meetings and their own professional development.

Good

Surgery

- We saw evidence from minutes of meetings that Infection control meetings occurred monthly, which were attended by representatives from each department.
- We reviewed records which confirmed hand hygiene audits were completed in compliance with the world health organisation (WHO) 'five moments of hand hygiene'. The audits highlighted that staff understood the key points at which hand hygiene should be completed.
- Disposable aprons and gloves were readily available so that staff could reduce the possibility of cross infection.
- Patient Led Assessments of the Care Environment (PLACE) were completed.
- Surgical equipment was sterilised on site in the Theatre Sterile Supplies Unit.

Environment and equipment

- There were 32 single rooms with en-suite facilities in the hospital, which cater for patients post operatively. The hospital has two operating theatres and a laser theatre for EVLA procedures; immediate post-operative recovery bays and a six bedded 2nd stage recovery unit. The hospital also has an on-site decontamination facility. We observed all of these areas and found them to be clean, well-maintained and fit for purpose.
- We found that mechanisms were in place to ensure no public access to theatres and other restricted areas. We found locks on door entrances and restriction signs for patients.
- Bi monthly Health and Safety meetings took place at the hospital, with representatives from each department. The meetings focus on different departments risk assessments, which enable the departments to gain a better understanding of each others risks. The meetings allow teams to follow other departments good practice and put systems in place in their own service to prevent accidents and incidents. We reviewed records which confirmed that the health and safety meetings were used to discuss hazards, risks, accidents and incidents and any changes in procedures or running systems. The Health and Safety representatives were also given advice and support on how to manage and control Health and Safety issues.
- We saw a copy of a health and safety report, which is published annually. The report provides an overview of performance in regard to Health and Safety and targets the forthcoming year's health and safety actions.
- Records we reviewed confirmed that each department had a health and safety representative who completed audits of the environment, on a monthly basis to ensure the environment and equipment was safe for patients and staff.
- Equipment on wards and in theatres was visibly clean. Items we checked were labelled with last service dates visible.
- Electrical equipment had been tested and dates of the last service were clearly marked on labels.
- We noted that, recovery rooms were well equipped to care for patients in the post-operative period before returning to the ward areas.
- We found emergency resuscitation equipment was in place in both inpatient wards and the theatres. Resuscitation trolleys we reviewed were visibly clean, and checklists were completed.
- We saw written evidence and were told verbally by the theatre manager that theatre equipment was monitored and maintained by equipment engineers.
- We noted that call bells were accessible in all areas so patients could call for assistance.

Medicines

- Medicines were supplied to the inpatient wards from the hospital dispensary. A dispensary assistant supplied by a local pharmacy supported dispensing five mornings a week. On inspection of the pharmacy we found paperwork which showed that a doctor or nurse checked all dispensed medicines to ensure safety.
- Whilst the hospital did not employ a full time pharmacist, pharmacist advice could be sought under a service level agreement (SLA) with a local pharmacist, when needed.
- The hospital had developed polices which allowed dispensing by doctors and appropriately qualified nurses outside these hours, ensuring discharge medicines were promptly available.

- Managers told us that the pharmacy SLA had recently been renegotiated with the pharmacy contract stipulating reviewing of medicines policy with twice-yearly Medicines Management Forums.
- Medicines including controlled drugs were safely and securely stored by staff.Medication in theatre had to be signed out by two qualified staff and was tallied by managers and audited by pharmacy.
- Medicines stocks were regularly date checked and expired items sent for safe disposal.
- Prescription stationery was securely stored.
- We looked at 14 prescription charts and found there was no clear procedure in place for medicines reconciliation. Two of the 14 prescription charts we looked at did not list all the patients' current medicines.However, nurses and doctors did speak with patients about their current medicines at pre-admission and again during their admission.
- Generally the prescription charts we reviewed were clearly presented and we noted that nurses monitored patients' pain to help ensure this was well managed.
- Patients' allergy status was noted on their prescription charts and red bands were used to highlight this during their admission.
- Records showed that nurses advised patients about whether they should take or omit their current medicines prior to surgery.
- Documentation we reviewed confirmed that most patients brought their own medicines into hospital and following an assessment of risk, continued to manage their own medicines during their stay.
- The hospital's 2016 patient survey showed that 94% patients gave a score of 'excellent' for pain control and 94% patients 'excellent' for information about medicines side-effects.
- The hospital had a medicines management policy which staff were aware of.
- The hospital had recently undertaken a medicines management audit. Records of weekly inpatient ward huddle meetings evidenced that medicine errors were discussed and brought to the nurses' attention.
- We found that safe administration of medicines training varied across the disciplines in inpatient and theatre staff groups. The hospital had a 90% mandatory training target for safe administration of medicines. In the wards 75% of nursing staff had received training but we found theatre staff training substantially higher at 90%.
- Staff confirmed that prior to administering medicines to patients they completed training and undertook an assessment of their competency to administer medicines.
- Medicines that required storage below a certain ambient temperature were stored in a locked fridge, which was only used to hold medicines. The minimum and maximum temperatures were checked daily and when required readings outside the safe parameters were reported.

Records

- Patient's records were held in paper format and also electronically.
- In the records we reviewed, we found two incidents where consultants had not signed to confirm surgical site markings for patients in theatre. Surgical site marking is a vital part of the preoperative process. Patient's surgery areas are marked to verify correct surgery areas to prevent wrong site surgery. Whilst the theatre staff had placed other checks and balances to ensure wrongful surgery did not occur, surgeons did not sign to confirm final verification during the "sign in" of the WHO checklist. This was raised with senior management during our inspection and we were given assurances that this had been dealt with in conjunction with theatre staff.
- The safety checklist was audited every three months to evaluate the efficacy of the checklist. The audit completed from May to July 2016 provided findings and objectives to improve performance.
- The hospital undertook monthly audits of records from a random sample of 20 patient files. In the quarter January 2016 to March 2016, theatre records were just under the target figure set by the hospital of 90% compliant, whilst inpatient ward records indicated a compliance figure of 95%.

- We looked at six sets of patients' records in the ward. We found them to be complete in terms of documentation, with the information being legible and they were easy to locate.
- There were pathway packs for day care procedures and inpatient procedures which incorporated pre-admission assessments, risk assessments, preoperative checklists, records from the surgical procedure, recovery room documentation, multidisciplinary team records, nursing and medical records, observation records, discharge check list and discharge.
- The hospital had undertaken an audit of records and availability of information. In the three months prior to our inspection 100% of patients were seen with all relevant medical records being available.

Safeguarding

- Records we reviewed confirmed that there were hospital wide safeguarding policies and procedures in place. Staff we spoke with in the teams told us they adhered to and understood the policy.
- The hospital had a named safeguarding lead who was the chief nurse and the staff we spoke with, were aware of her role. The safeguarding lead provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards.
- We observed a Safeguarding pathway diagram on the wall of the ward, which staff could use to decide if a situation required escalation.
- The hospital did not treat children but safeguarding children training was undertaken by staff as part of the mandatory training programme. The training was due to the fact that young people visited their parents and grandparents in the hospital.
- Fairfield had a Safeguarding lead for Children who is the ward manager. We were told by senior managers that the Ward Manager was a Registered Sick Children's Nurse and was trained to Safeguarding Children Level 4.
- The staff we spoke with clearly understood the process of contacting external safeguarding teams who could provide guidance and support to staff during normal working hours.
- We found that safeguarding adults level 2 training varied across all of the disciplines in both ward and theatre staff groups but levels were overall positive. The hospital's compliance target was 90% at the time of inspection. We found that in the ward 85% of nursing staff and 95% of healthcare assistants had received safeguarding adult's level 2 training. In the theatres 90% of trained staff and 100% of healthcare assistants and porters had received safeguarding adult's level 2 training.

Mandatory training

- The hospital provided us with their mandatory training records and we discussed training with staff. Mandatory training provision in the hospital was delivered either by face-to-face training or by e learning. The training was delivered by both internal staff and external providers. The training included advanced life support, dementia, and safe administration of medicines, management, infection prevention, consent and mental capacity.
- Mandatory training compliance was high and generally over the 90% mark which is the hospital compliance target. The only areas of low compliance in mandatory training were safe administration of medicines at 75%, fire awareness at 80% and safe guarding adults training at 85%, all of which were in the inpatient registered nursing team. We found no evidence of how this was being resolved in the hospital.
- The hospital did not deliver mandatory training to its consultants, apart from induction. Resident Medical Officers [RMOs] are expected to be up to date with their employing agency. Records we reviewed confirmed that their mandatory training compliance was checked each year to ensure they had the necessary skills and training.
- Documentation confirmed that new consultants at the hospital were required to attend an induction to the hospital which included fire safety and policies and procedures.
- The majority of Resident Medical Officers were employed through an agency with which the hospital has a service level agreement. The hospital and agency provide training and continued professional development (CPD) and this is regularly reviewed by both parties. The employing agencies have

responsibility to ensure that medical staff hold Advanced Life Support (ALS) and take the lead during Resuscitation scenarios at the hospital. The company ensures that RMO's complete a yearly update of training.

Assessing and responding to patient risk

- Records we reviewed confirmed that patients were screened and assessed using the hospital's internal referral guide. This identified patients for whom treatment at the hospital was not appropriate due to the risk of needing high dependency recovery facilities. This formed the initial line of patient risk assessment.
- We were told by inpatient staff and managers that patients were seen in the outpatient department before they were admitted for surgical procedures. The contact provided opportunity to check the patient understood their admission and for assessment purposes. The staff also checked that patients were not suffering any illness or infections, such as a cold or upset stomach or other symptoms that could pose a risk to their health if they underwent surgery. If any risks were identified, surgery was postponed till they were medically fit.
- The hospital used the World Health Organisation (WHO) 5 steps to safer surgery check list. The WHO checklist is internationally recognised system of checks which is designed to prevent avoidable harm and mistakes during surgical procedures.Records that we reviewed confirmed that the theatre department had implemented the World Health Organisation (WHO) safety checklist for non-surgical interventional radiology.
- The hospital used a nationally recognised Early Warning Score [EWS] which identified patients who were at risk of deteriorating. The system provides guidance for staff about what action to take if the patients are at risk of deteriorating.
- We saw evidence that patient risk assessments were being completed before surgical procedures were undertaken and screened by nursing staff on the inpatient ward. These assessment included assessment of falls, moving and handling and Malnutrition Universal Screening Tool (MUST) score.
- The hospital also had a service level agreement with the critical care network.
- The hospital had a deteriorating patient policy, staff we spoke to were aware of the policy and were able to provide us with information on what they would do if a patient was to deteriorate on the department.
- Patients who were of child bearing age were asked by staff if they could be pregnant and when they had last menstruated before surgery. The answers were documented and a sticker was placed in the patient notes to document the date of last period and to record if the patient was pregnant. The process was done to ensure that patients were treated correctly both surgically and in relation to medication support. Staff were aware of this process and were able to demonstrate the use of the procedure to follow.
- The wards used safety huddles as a way of sharing important information on patients across the team. The safety huddles were used at transfer of shift and were present when this was being undertaken.
- The hospital used a venous thromboembolism risk assessment (VTE), which assess the likelihood of of patient developing a venous blood clot. Records confirmed that in the period April 2015 to March 2016, 100% of assessments had been completed.
- A training log provided by Fairfield showed all ward and theatre staff received training in intermediate life support (ILS) as part of their mandatory training.
- A resuscitation trolley was easily accessible in the department. We observed records that it was checked daily and that all the necessary equipment was available and in date.

Nursing staffing

- There are no national requirements in respect of skill mix on hospital wards. We found in the ward area of Fairfield there were a total of 15.6 trained nursing staff and 10.6 Healthcare assistants, which equates to a ratio of 1 nurse to every 0.68 health care assistants. The staff told us that they felt the wards were well staffed and had a good skill mix.
- In the theatre areas there were a total of 8.4 trained nursing staff and 9 healthcare assistants (HCA) and operating department practitioners (ODPs), which equated to a ratio of 0.93 nurses to every 1 health care assistant.

Good

Surgery

- The hospital provided us with data on the wards use of bank staff for inpatient nurses, from April 2015 to March 2016. It showed low use of bank staff when we compared this to the yearly average of other independent acute hospitals.
- The hospital provided us with data on the use of bank staff for theatre nurses, from April 2015 to March 2016. It showed low use of bank staff when we compared this to the yearly average of other independent acute hospitals.
- Staffing levels on the ward were pre planned through estimation at a weekly activity meeting. The numbers of staff required was calculated using a recognised safer staffing tool adapted to meet the needs of the hospital.
- We were told by the nurse in charge of the inpatient wards that the staffing levels/skill mix required on a daily basis was also pre assessed at 7 am by the staff team. The assessment was done on the ward, every day, to ensure the ward had enough staff on duty. The ward displayed its nurse and HCA information on a board at the ward entrance. The information showed the planned and actual staffing levels.
- On the two days of the inspection the number of staff displayed on the boards equated with the number of staff planned to be on duty.
- Information received from the provider prior to inspection showed that there were no unfilled shifts between January 2016 to March 2016 in both inpatient wards and theatres. This was confirmed by staffing rotas we looked at during out inspection.
- The hospital provided us with data on rates of staffing prior to the inspection. The overall vacancy rate for inpatient wards was 6% which equated to 1 FTE for nursing staff, Healthcare assistant vacancy rates were 0%.
- The overall vacancy rate for theatre staff was 11% which equated to 1 FTE for nursing staff, health care assistant vacancy rates were 0%.

Surgical staffing

- The hospital told us that they had no full time employed consultants in its staff group. The consultants were employed by the NHS and worked under practicing privileges. Practicing privileges allow a hospital such as Fairfield permission to employ medical practitioner on a private basis.
- As part of the pre inspection information provided by the hospital, we were told that out of hours the hospital provided a team of on call theatre staff. The staff were available for emergencies in the event of a concern or emergency cover because of sickness. The theatre staff confirmed this to be the case in interview at our inspection.
- Annual leave and sickness in consultant staff was covered by colleagues in the consultant's speciality and on occasions where this couldn't be done, the surgery for the consultant's patients was cancelled.

Major incident awareness and training

- The hospital had a major incident policy which included fire, intruder, stolen property; bomb scare, power failure, gas/water leak, telephone or service failure.
- Staff we spoke with were able to confirm they were aware of the policy and their role in the event of an incident or emergency.

Are surgery services effective?

Good

We rated effective as 'good' for surgery. This was because;

- We found that care was delivered from an evidence base and was in line with nationally agreed policies and practice.
- Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- The staff in both theatre and inpatient wards were supported through appraisal which was undertaken annually.
- We found100% of nursing and healthcare staff across the theatre department had received an annual appraisal in 2016.

- We found 88% of nursing staff and 100% of healthcare staff across the inpatient department had received an annual appraisal in 2016.
- Audits were undertaken and reviewed on an annual basis to identify learning and improve effectiveness.
- The hospital participates in Patient Reported Outcome Measures PROMS for NHS patients and had recently just started collection for private patients.
- Staff receive training on the Mental Capacity Act and Depravation of Liberty Safeguards. We reviewed the mandatory training log held by the provider and this showed all theatre and ward staff were at 100% compliance for consent and MCA training.

Evidence-based care and treatment

- Policies and guidelines were developed based on both NICE and Royal College of Surgeons [RCS] guidance and were available to all staff. This included the use of early warnings (EWs) charts used to identify and take appropriate action when a patient's condition was deteriorating. (NICE guidance CG50).
- There was an extensive audit cycle set by the theatre department which reviewed clinical practice by clinicians and by procedure over the previous 2 months. Audits included Asepsis audits for both wards and theatre, and hand hygiene audits for both wards and theatres. The hospital also undertook records audits in both areas.
- The Joint Advisory group (JAG) is responsible for accrediting Endoscopy units in the United Kingdom and sets safety standards. We saw evidence of a self-assessment undertaken by Fairfield in April 2016 by a lead clinician in endoscopy. A further full JAG assessment date was planned for May 2017. The hospital scored well on the audit and had set out an action plan to target the audit recommendations.
- We saw an audit of endoscope decontamination facilities undertaken on 12/04/2016 as part of the internal JAG assessment. The hospital had identified a number of actions which it included in its JAG action plan.

Pain relief

- The hospital uses a nationally recognised pain scoring tool [NEWS]. NEWS is used to recognise patient deterioration and increase in pain, enabling staff to respond appropriately in their care of the patient. Records we reviewed confirmed that staff were using the NEWS tool in order to respond to patients who may need extra support, in an effective manner.
- We found there were processes in place to assess patient's pain levels and act appropriately. Pre-operative assessment for all patients included details of post-operative pain relief. This ensured that patients were prepared for their surgery and were aware of the types of pain relief available for them.
- We reviewed 39 patient satisfaction questionnaires from July 2016 and 100% of patients reported that if they suffered pain it was adequately controlled. From the questionnaires, 100% of patients also reported that side effects of any medication were explained to them.

Nutrition and hydration

- Patients are assessed using the Malnutrition Universal Screening Tool [MUST], this system highlights to staff that the patient may require extra assistance with their nutrition and hydration, or a special diet, utensils, etc.
- Records we reviewed confirmed that patients' nutritional risks were assessed pre-operatively and also daily when admitted. Additional supplements could be provided if nutritional concerns were identified in the pre-operative assessment.
- The chef ensured their individual nutritional needs were met and these were highlighted at both pre assessment and after admittance onto the ward. The hospital took into consideration vegetarian and halal options for patients.
- Patients were advised of the time they needed to starve fast pre operatively, this included when they could have their last meal and when they could have their last drink. The information was rechecked on admission.

Patient outcomes

- We reviewed an audit plan for 2016-2017. The hospital had planned nineteen audits across a wide range of subjects', for example an audit of "checking lone equipment" and "the effectiveness of a pre operation huddle". We saw evidence of a Quality Assessment

Document (QUAD) audit which had been reviewed and discussed in a department heads meeting. The QUAD had been completed in theatre. We also saw a range of planned audits in conjunction with commissioners.

- Data received from the provider prior to inspection showed that theatre staff undertook the Association of Perioperative Practice Risk and Quality Management system audit on a yearly basis. This was confirmed by records we reviewed as part of the inspection.
- The hospital participates in the National Joint Registry (NJR) data collection.The NJR monitors best practice compliance in replacement of joints. The latest data from the NJR 2014/2015 indicates that Fairfield is 99.26% compliant against the national benchmark figure of 95%.
- The hospital submitted to the Patient Reported Outcome Measures (PROMs) but as yet not enough data has been recorded to provide a bench mark. Proms assess the quality of care delivered to NHS patients from the patients' perspective. PROMs calculate health gains after surgical treatment using pre- and post-operative surveys.
- The hospital provides data for both internal and external committees and has a dashboard of Key Performance Indicators [KPI's] s that is reported to the Board and to the MAC.
- Staff told us in interview that they completed a food allergy, nutrition and diet update on a yearly basis as part of their training. The update includes when to escalate concerns if a patient has not had fluid or diet.
- Patients with learning disabilities or with a cognitive impairment such as dementia were offered pictorial menus.
- We were also shown how patients were offered colourful food on a white plate on a black tray, where appropriate.

Competent staff

- The appraisal process helps to ensure that staff have the skills and training necessary to deliver on their personal job objectives and those of the organisation. The last full year rates of appraisal in theatre and ward staff in Fairfield were as follows; Inpatients health care assistants were at 100%, theatre nursing & midwifery registered staff was at80% , theatre ODP registered and Health care assistants was at75%.
- Mangers told us that all new staff were required to attend corporate induction days held at the hospital. We met two staff who had recently gone through induction and they had found the experience positive. The two staff members told us that during induction, they were also introduced to key management including the Chief Executive and the Board as well as being informed about important policies and procedures.
- Each department developed their own specific induction programme for new staff. Staff confirmed they had completed the organisation's induction day and their local area induction programme.
- All staff we spoke with told us there were good educational and developmental opportunities available to them, regardless of role. Fairfield usually funded these opportunities and staff spoke positively about management investing in staff. In addition, staff told us they were supported to attend regional and national conferences and networking opportunities. In the theatre and ward settings, we also met health care assistants who told us they were supported to develop their skills and knowledge.
- In the course of the inspection, the hospital had reviewed its surgical first assistant role and followed the recommendations for the role set out by the Royal College of Surgeons in 2011. The hospital had developed a specific job description for a surgical first assistant and the role had been separated from a scrub practitioner as required by the royal college.
- We saw written evidence of Service Level Agreements (SLAs) which existed between the hospital and other services. The SLAs were essential to the care and treatment of patients.
- The Day unit manager stated that there were good relations between the wards and theatre staff. The staff in both teams confirmed this. We found evidence of operational managers from across the hospital meeting regularly in order to improve patient's pathways and clarify issues.

- Daily 'Huddle' meetings meant that leads from all disciplines met to discuss and resolve any issues ensuring effective multidisciplinary working.
- Staff reported an ethos of multidisciplinary working with the theatre and nursing, departments and pharmacy working effectively together to achieve the best outcomes for patients.
- The patient records we reviewed evidenced the involvement of the multidisciplinary team.

. **Seven-day services**

- Theatre one was normally staffed from 8.00- 20.00 Monday to Friday and occasional Saturdays if required. Theatre one session times were 08.30 -12.30 13.30 - 17.00 and 17.00 -20.00.During the working day a number of specialities used the theatre, mainly for orthopaedic surgery.
- Theatre two is staffed from 8.00 - 20.00 Monday to Friday. The session times were 8.30 -12.30 13.30 - 17.00 and 17.00 - 20.00.The theatre was used for all surgical specialities with the exception of open orthopaedic surgery.
- Theatre three was not situated within the theatre environment. The service was a completely enclosed laser safety environment. The Consultant led service offered a "walk in, walk out" treatment for the removal of varicose veins under local anaesthetic using a specific laser. Although within the ward area this service is operated as a minor surgery clinic.
- Pharmacy services were available five mornings a week. Outside of these hours the RMO and ward manager could access a local pharmacy to dispense medicines. An on call pharmacist was available for advice out of hours. Staff reported they could access pharmacy advice at all times.

Access to information

- We found patient records were accessible on the wards and departments. The staff reported no concerns with accessing patients' records or relevant test results.
- The hospital told us that there were processes in place to ensure discharge summaries were provided to GP's within 24 hrs. Records we reviewed during our inspection confirmed this.
- The hospital had developed Standard Operating Procedures (SOPs), on patient transfer. Processes were in place to ensure patients' information was transferred to the receiving hospital if the patient's care had to be transferred due to their clinical condition.
- In the course of the inspection we observed that nursing stations and offices had access to the hospital computer system. The systems were password protected.
- Policies and procedures were available on the hospital shared hard drive and staff were aware of how to access them. We saw that policies and procedures had been reviewed and were updated.
- We viewed noticeboards in the nursing base stations that showed safety information and highlighted incident reporting statistics.
- Staff in both teams told us that information from team meetings was e-mailed to staff and displayed in staff areas to read and sign.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff said they had completed training about the Mental Capacity Act [MCA] 2005. We reviewed the mandatory training log held by the provider and this showed all theatre and ward staff were at 100% compliance for consent and MCA training.
- Staff demonstrated in conversations a good understating about processes that need to be followed if a patient had a suspected reduced mental capacity to make informed consent about procedures.
- The ward had a specific room targeted at supporting individuals who had mental health or cognitive or impairment issues. We noted that this was located close to the nursing hub.
- The hospital completed a consent audit in May 2016 and found that consent was appropriately recorded in 98% of records against a hospital target of 95%.
- We reviewed ten patient records that required a surgical procedure, and found that consent to the procedure had been documented in all records. Consent was also confirmed on the day of the surgery and this was documented in all the records we reviewed. However, although all consent forms had been signed, not all

consent forms had been completed fully. In three consent forms we found there were omissions in the completeness of the form which included documenting, gender, staff job title and date.

Are surgery services caring?

Good

We rated caring as 'good' for surgery. This was because;

- All the patients interviewed by us provided good comments about the quality of service that they received from staff in the hospital.
- We were present when care was being delivered in both areas of the ward and in theatres settings. In all cases the staff treated patients with dignity and respect.
- All the staff interviewed told us that they put patient care first and were very passionate about the care that they delivered.
- It was evidenced in the comments made by patients that they felt supported both physically and emotionally.
- Patient's records indicated that patients were fully involved in the decisions about their care.
- Patient's privacy and dignity was maintained. Patient's feedback was actively sought.

Compassionate care

- We spoke with three patients as part of the inspection. They all told us that staff were caring and treated them with dignity and respect. One patient told us that they received "excellent service from all staff including the consultant".
- Patients commented positively about the nursing care they received. A patient stated that they were "very pleased with the care and treatment by all the staff".
- The staff placed patient need first and showed us they were keen to engage individuals in their treatment and put their minds at ease. The staff understood the anxiety of patients who were going to attend surgery and told us their first priority was to alley anxiety.
- In discussion with us, staff were knowledgeable about the need for confidentiality and described to us the ways in which they tried to respect patient's privacy and dignity this at all times.
- We noted that all treatments were carried out in private rooms and there were many opportunities for patients to have a private and confidential conversation if required.
- The staff were observed both speaking to patients on the phone and in face to face contact. We noted that during our observations patients were dealt with sensitively and politely.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patient satisfaction with the healthcare they have received. For the months March, April, May 2016, FFT showed over 96 % of admitted patients were extremely likely or likely to recommend Fairfield.
- We saw notices which confirmed that chaperones were available for all consultations and surgical procedure's if and when required.
- The hospital's patients questionnaire from April 2015 to March 2016 showed that 100% of patients considered the staff to be support and reflective of patient need.

Understanding and involvement of patients and those close to them

- Discussions and decisions about treatment were made at pre-operative assessment clinics based at hospital. This meant when the patient was admitted to the hospital they already had a good understanding about the care and treatment they were going to receive.
- Patient opinions were sought through the use of a patient questionnaire which were left for patients to fill in at the end of each patients stay.

  Written information for patients we reviewed was only in English. Staff told us they were able to request information in differing formats if required.

  Patients who paid for treatment were informed of the costs before consultation and treatment so they were aware of the costs.

Emotional support

Good

Surgery

- We observed staff providing reassurance and emotional support in all surgical areas.
- Patient could contact the hospital 24 hours a day after they were discharged for support and advice if needed.
- Information was displayed in the department so that patients could source help. An example of this was that patients' families were well supported with information and facts about dementia as well as contact numbers nationally when needed.

Are surgery services responsive?

Good

We rated responsive as 'good' for surgery. This was because;

- Surgical services were responsive to the needs of people; admissions for surgery were staggered throughout the day so patients did not experience long waits after being admitted prior to their procedure.
- Patients were able to influence the choice of date and time for their surgery.
- The departments were able to be flexible to accommodate patients individual needs, there were good examples of staff adapting procedures to meet the needs of patients with specific needs.
- There was an effective process for managing and learning from complaints.
- There was ample car parking at the hospital which was free of cost for patients and visitors

However,

- At times surgical procedures lasted longer than expected causing some patients to wait longer than originally intended.

Service planning and delivery to meet the needs of local people

- The hospital catered for a wide range of patients across differing communities in the North West of England.Written literature was not obvious in alternative formats and languages. However staff told us that they could print information off if necessary.
- Admissions to theatre were staggered to ensure patients were able to remain in the comfort of their own homes rather than endure long anxious waits for theatre, however at times surgical procedures lasted longer than expected causing some patients to wait longer than originally intended.
- We reviewed cancelations of surgery in the hospital. Fairfield Independent Hospital reported 134 cancellations of procedures for non-clinical reason in the 12 months previous to our inspection. The hospital tried to re book patients into surgery quickly. 104 patients were offered another appointment within 28 days of the cancelled appointment.

Access and flow

- Surgery scheduling meetings occurred on a regular weekly basis and involved staff from all areas, including the ward. This meeting was used to review the needs of scheduled patients and ensure additional staffing could be accessed if required.
- NHS patient waiting times were calculated on a monthly basis at Fairfield. The hospital has not breached the NHS England targets for waiting times or diagnostic waiting times.Private patient waiting times were dictated by the terms of the contract with private organisations who commissioned treatments.
- The most recently published data showed Referral to Treatment (RTT) waiting times targets were met averaging above 90% for the entire reporting period (April 2015 to March 2016).
- Dates for admission for surgery were discussed at initial outpatient's appointments. Patients were able to make individual choices about their preferred date and time of day of surgery.

Meeting people's individual needs

- Patients were described by staff as being at the centre of the care received. Staff described feeling enabled to make changes to suit the patients' best interests and choices.
- Where patients were identified as having additional needs at pre-assessment, additional ward staff were provided if one to one support was felt necessary.

Patient's relatives could also stay overnight to support individual's pre and post-surgery. Examples of when this might occur were for patients with learning difficulties disabilities or those diagnosed with dementia.

- On the inpatient ward a dementia room had been developed which was close to the nursing station. The ward had items designed to support patients living with dementia. The department had adapted ward space, including coloured toilet seats. We were informed by managers that new signage had been ordered for the toilet doors to help make wards and amenities visually clearer for those patients living with dementia.
- A symbol was used in patient records to identify those patients who were living with dementia to ensure patients received the support they required from clinical and nursing staff.
- In discussions staff demonstrated a good understanding about the effect a strange environment might have on someone who has cognitive deficits as a result of dementia, a learning disability or any other medical condition. This provided assurance that staff were able to meet the individual needs of patients.
- The hospital had produced a pledge to dementia suffers informing families and individuals on what they could expect whilst in the hospital. The pledge also had a number of outside resources contact numbers.
- The hospital chef carried out regular audits to ask patients for comments on the menus they have been offered.
- The surgical ward consisted of 32 single rooms; we noted that all rooms were single sex.
- The hospital had a diversity and equality strategy that was issued in January 2015.
- The hospital also provided a hearing loop system which was available for those patients that had hearing difficulties.
- For patients whose first language was not English an interpreting service was available. We heard reports of patients who were using relatives as interpreters. However, staff on the wards said this rarely occurred and there was usually no problem with accessing interpreting services.
- Pre-operative assessments were carried out on all patients which were used to assess future need after surgery was undertaken such as raised seats and frames.

Learning from complaints and concerns

- We saw evidence that complaints were dealt with by managers in the theatre and inpatient wards. Issue were dealt with quickly and by staff who understood the service. Staff told us that if they were unable to resolve a complaint at the first stage then it would be escalated to a manager. If the manager in turn could not resolve the concern it would be escalated to senior management.
- Records we reviewed confirmed that complaints were acknowledged within two days of receipt and the hospital aimed to have a full response within 20 working days.
- The hospital had a total of 39 complaints within the reporting period from April 2015 to March 2016. The CQC compared this to other independent acute hospitals and it was low.
- We saw evidence that the service recorded complaints on the hospital wide complaints system.
- Patients could request a meeting with the chief executive if the concern warranted it.
- The chief executive was ultimately responsible for overseeing complaints within the departments and the hospital. This included initial acknowledgement, investigation and final response.
- We saw evidence which confirmed that complaints received were discussed at ward meetings, and governance meetings and changes were made in practice where applicable.
- Staff we spoke with were aware of the complaints procedure and knew how to manage a complaint in line with the policy and procedures.
- Patients we spoke with said there was nothing to complain about, but if they had a complaint they had confidence it would be managed in a sensitive and appropriate manner.
- The hospital provided information on its website and within a folder in each of the patient rooms on how to make a compliant. The hospital also advises patients on

what to do if they are not happy with their response to their complaint and who they can escalate their concerns to. The information includes contacting the local CCG or NHS England or the Parliamentary and Health Service Ombudsman.

Are surgery services well-led?

Good

We rated well-led as 'good' for surgery. This was because;

- We found that there was a robust governance framework within the service and senior managers on the whole were clear about their roles and responsibilities.
- Learning from incidents was addressed via team and one to one meetings with staff. The results of audits across surgical and inpatient departments were disseminated to the relevant staff groups on a regular basis.
- The hospital had set out a strategic plan for 2015 to 2020 that incorporated a mission and a vision for the hospital.
- The hospital had a documented risk register which highlighted risk and mitigated risk to reduce the impact on patients. The risk register covered a number of areas including staffing, medicine management, and infection control.
- The hospital had ensured there were checks and balances in place for consultants and documentation was in place to ensure tracking of practicing privileges by the Medical Advisory Committee (MAC).
- We found in the last staff survey in 2016 that 97% of staff employed would recommend the hospital as a provider of care to their friends and family.
- Patient questionnaires were undertaken on a daily basis by the hospital to gain patient feedback. The questionnaires ask patients to comment on staff professionalism, conduct and attitude. The last quarter results before our inspection show patient satisfaction rates on average at 99.5% satisfaction rates.
- We found staff in the hospital were extremely passionate about the service they provided to patients. The staff also positively commented on the facilities they worked in.
- We saw from governance meeting minutes that improvements were discussed and areas of improvement identified.
- At the time of inspection the hospital was in the process of becoming JAG accredited. The Joint Advisory group (JAG) is responsible for accrediting Endoscopy units in the United Kingdom and sets safety standards. We saw evidence of a self-assessment undertaken by Fairfield in May 2016, with a further full JAG assessment date planned for May 2017.

Vision and strategy

- The staff in the hospital were extremely passionate about the service they provided to patients. The staff positively commented on the facilities they worked in.
- The hospital had produced a five year strategic plan from 2015 to 2020. It's aim was to improve the health of the people in the North West of England, through affordable high quality care. The hospital planned to do this by providing high quality medical facilities with motivated staff in a safe and sustainable environment.
- Staff were aware of the hospital vision and management had kept them abreast of future changes in the hospital.

Governance, risk management and quality measurement

- We saw records which confirmed that there was a structured governance programme in the hospital and meetings were well attended and minuted.
- Records which we viewed evidenced that surgical specialty groups and inpatient wards, held meetings to focus on good governance. These meetings supported shared learning and consistency in monitoring of quality across the centres.
- Audit programmes planned by the hospital were detailed and audits were undertaken in a number of areas. The results were fed into the wider organisation and shared learning fed into the governance process of the treatment centre. We reviewed documentation which conformed that this process was on going across the service.
- The hospital had a risk register which flagged up risks across the hospital as well as in the theatres and inpatient areas. The registers showed how risk was

managed, reviewed and mitigated across the hospital. The risk register for the surgical service fed into a corporate register and staff could add items on to risk area as needed.

- Department managers fed into the corporate register by rating the risk as either red amber or green. A risk matrix was used to calculate the severity of the risk and high risks were transferred onto the corporate risk register. Information was also disseminated by e-mailing the staff teams to ensure all staff had the latest information.
- We saw that minutes of team meetings were kept and staff confirmed that meetings took place. Consultants who provided medical input had valid practicing privileges and each application for practicing privileges was reviewed by the Medical Advisory Committee (MAC) for approval.
- Records we reviewed confirmed that the Chief Medical Officer (CEO) checked consultant's documentation four times a year and liaised with the MAC if any issues arose. The hospital liaised with the consultants employer and contributed to the consultants appraisal process, identifying any areas of concern as well as compliments.
- The MAC met quarterly and we saw evidence of its meetings. The department had service level agreements (SLA's) with different organisations. These organisations provided services to the hospital to ensure the hospital was able to function. These services included pathology and medical equipment maintenance. We saw that contracts were in place and review dates documented.

Leadership and culture of service

- The executive team told us that they had developed an open door policy for new starters where new staff met the executive team on an individual basis as part of their induction. Staff we spoke with confirmed this.
- The managers of the theatre department and inpatient areas were visible in the departments and we observed managers providing visible positive engagement with the staff and the staff group.
- Managers we spoke with displayed an all-round knowledge of their areas of responsibility and they understood the risks and challenges to the services they managed.
- The staffs told us they enjoyed coming to work and were genuinely proud of working for the organisation.
- The staff told us that managers were approachable and listened to issues that they might have. Staff we spoke to had no concerns at the time of inspection and reported that they felt valued and appreciated.
- The staff in the hospital were extremely passionate about the service they provided to patients. The staff also positively commented on the facilities they worked in.
- The staff told us that there was an open and happy culture in the hospital but a number told us that change had occurred over the last year, where management seemed more business-like and target orientated.
- We found that the leadership had provided training and support to staff and were aware of staffing issues in their own services.
- The hospital's staff survey in 2015 showed that 82% of the staff recommended the hospital as a place to work. The average response rate was 60%. In the same survey, 97% of staff employed would recommend the hospital as a provider of care to their friends and family.
- Executives and clinical managers were known by the staff and were highly visible across the hospital. Staff described seeing executives on a daily basis and said they were approachable at all times.
- Most staff spoke highly about their individual managers, about the support they provided to themselves and to patients. All staff said they were supported to report concerns to their managers who would act on their concerns. They said that their managers updated them on issues that affected the unit and the whole hospital.

Public and staff engagement

- The results of the NHS Friends and Family Test For the months March, April, May 2016 showed that the hospital sought feedback from the public. FFT showed over 96 % of admitted patients were extremely likely or likely to recommend Fairfield.
- We saw evidence of patient satisfaction questionnaires in every room on the wards of the hospital. The questionnaires were reviewed daily by senior managers to ensure that issues were dealt with quickly. Results from the hospital's 2015/2016 patient survey showed that 100% of patients would recommend the hospital to a friend or family member and 99.55% would rate the overall standard as very good or excellent.

Good

Surgery

- We saw from letters written by the chief executive to patients that responded to identified issues so that concerns were quickly expedited.

Innovation, improvement and sustainability

- We saw a positive approach to evaluating performance and making improvement when needed. The strengths and weakness of departments were discussed in governance meeting minutes and appropriate processes put in place where needed. The board of trustees provided a level of challenge, ensuring that the organisation made improvements when required.
- The hospital had implemented Knee Replacement surgery using 3D Printer Technology.

Good

Outpatients and diagnostic imaging

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

Information about the service

The Guy Pilkington Memorial Home Ltd operating as Fairfield Independent Hospital is a registered charity. The Hospital first opened its doors in 1974 as a home for the elderly. There was a perceived need locally for a private hospital that could support Pilkington's employee's welfare and the role gradually increased to providing Hospice beds and more nursing care. In 1975 the Hospital opened with one operating theatre and twenty beds and became more focussed on surgery and outpatient treatment.

Fairfield Independent Hospital is an independent not for profit charitable organisation, and has been providing independent healthcare for 43 years.

From April 2015 to March 2016 the Hospital saw 47,347 patients and until recently in 2016 offered services to children under the age of 16. Approximately 70% of patients were NHS funded and the other 30% were privately funded.

The main specialities seen in outpatients and diagnostics are trauma and orthopaedics (28%), ENT (17%), general surgery (16%), ophthalmology (8%), gynaecology (7%), urology (6%), gastroenterology (6%), plastics/cosmetic (4%) and dermatology (2%). A further dozen specialities are also provided but they, in total, provide less than 5% of their activity. In addition there are radiology sessions and physiotherapy.

The Hospital has a full range of diagnostic facilities including plain, fluoroscopy, ultrasound, mammography imaging and laser surgery. MRI and CT scanning are provided by mobile external providers who visit on a weekly basis.

Summary of findings

We rated Outpatients and Diagnostic imaging as 'Good' because;

- Between April 2015 and March 2016 there were no incidents categorised as severe reported in outpatients or diagnostic services at the hospital. If a serious incident did occur, we saw there was a process to investigate them using a root cause analysis (RCA) approach and share learning.
- From April 2015 to March 2016 there had been no incidents of Methicillin-resistant Staphylococcus aureus (MRSA), Meticillin sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C.diff), or Escherichia coli (E.coli).
- There was one vacancy for a qualified nurse on the outpatients department. All other areas were fully staffed and the staff turnover within the reporting period was 0%.
- Medicines were stored securely in a locked cupboard and all were in date.
- Patient records were made up of a combination of paper records and electronic records. Paper records were set up for use in each clinic to enable the consultant to record the consultation and any planned treatment. Once the consultation was completed the records were then scanned into the electronic system as a permanent record. The system ensured that all previous appointment records were always available to the consultant.

Good

Outpatients and diagnostic imaging

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- The Radiology department had implemented the World Health Organisation (WHO) safety checklist for non-surgical interventional radiology. The safety checklist was audited every three months to evaluate the efficacy of the checklist. The audit completed from May to July 2016 provided findings and objectives to improve performance.
- There were local audit programmes for outpatients, radiology and physiotherapy. There were monitoring arrangements in place to review findings of audits and monitor progress. Audits included auditing of records and MRSA.
- Consultants at the hospital were only granted practicing privileges once approved by the Medical Advisory Committee (MAC).
- All staff (100%) in the OPD had completed training in consent and mental capacity act. Within radiology and therapy 90% of staff had completed mental capacity act training and 100% of staff had completed the consent training.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. We observed how staff interacted with patients and their families and found them to be polite, friendly and helpful. We saw that staff introduced themselves and acted in a courteous and professional manner.
- Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs. Clinic times were available up to 8pm on week days and clinic appointments were available on a Saturday to meet the needs of the patients.
- The department audited patient waiting times to ensure patients were seen within 30 minutes. The hospital target for 30 minute waiting times was 90%. From January to June 2016, outpatients had exceeded this target. In June 2016 the department saw 95% of patients within 30 minutes.
- All staff told us that managers of the service were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.

However,

- We found that only three out of six staff we spoke to were clear on the term Female Genital Mutilation (FGM), even though managers informed us that FGM was covered as part of the safeguarding mandatory training. We found that FGM was included in the children's safeguarding policy but was omitted from the adults safeguarding policy. Subsequently, patients who were at risk of FGM may not be properly identified and safeguarding procedures followed.
- Mobile scanning units attended the hospital twice weekly; we found that during the time the scanning units were in attendance, there was no dedicated resuscitation equipment for its use in a resuscitation emergency. We were informed that in the event of a resuscitation emergency, the resuscitation equipment would be taken from the outpatients department. This potentially leaves patients vulnerable should they need urgent resuscitation.
- Staff we spoke to knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care. Staff understood the application of considering capacity, consent and deprivation of liberty. However, although all consent forms had been signed, not all consent forms had been completed fully. We reviewed ten consent forms in patient records and found that in four consent forms there were omissions in the completeness of the form that included documenting, gender, staff job title and date.
- Risk assessments were completed by department managers and RAG rated from Red to Green. A risk matrix was used to score the severity of the risk. A score above 15 should be highlighted to the senior

Good

Outpatients and diagnostic imaging

management team for consideration for inclusion on the hospital risk register. However we found that the calculation of risk severity using the risk matrix was not always completed accurately meaning that some department risks were not being highlighted to the senior management team. We found a total of eight risks assessments from a total of 22 that had a risk score of 15 that were not highlighted on the hospital risk register or may have been miscoded.

- Not all risk assessments for the department had been carried out with actions to mitigate the risk. For example, when the resuscitation trolley is used by the mobile scanner on a weekly basis, this leaves the department without resuscitation equipment. We saw no formal evidence that this had been risk assessed by the department.

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging as 'good' for safe because;

- Incidents were reported using a paper based reporting system. Staff could describe how to use the system and the types of things that would constitute an incident. Staff told us they received feedback when they reported an incident through team meetings and through daily safety huddles.
- Between April 2015 and March 2016 there were no incidents categorised as severe reported in outpatients or diagnostic services at the hospital. If a serious incident did occur, we saw there was a process to investigate them using a root cause analysis (RCA) approach and share learning.
- From April 2015 to March 2016 there had been no incidents of Methicillin-resistant Staphylococcus aureus (MRSA), Meticillin sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C.diff), or Escherichia coli (E.coli).
- We reviewed 39 patient satisfaction questionnaires for July 2016 and found that 100% of patients were satisfied that they had any side effects to any medication explained to them.
- The outpatients department displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements.
- There was one vacancy for a qualified nurse on the outpatients department. All other areas were fully staffed and the staff turnover within the reporting period was 0%.
- From January to March 2016 less than 1% of patients were seen in outpatients without all medical records being available.

However,

Good

Outpatients and diagnostic imaging

- We found that only three out of six staff we spoke to on the department were clear on the term female genital mutilation (FGM) even though managers informed us that FGM was covered as part of the safeguarding mandatory training. We found that FGM was included in the children's safeguarding policy but was omitted from the adults safeguarding policy. Subsequently, patients who were at risk of FGM may not be properly identified and safeguarding procedures followed.
- On the days where the Mobile scanning units attended the hospital, we found there was no dedicated resuscitation equipment for its use in a resuscitation emergency. We were informed that in the event of a resuscitation emergency, the resuscitation equipment would be taken from the outpatients department. This potentially leaves patients vulnerable should they need urgent resuscitation.
- Outpatient's mandatory training figures showed in June 2016 they were just below the hospital target of 90% at 87%.

Incidents

- Incidents were reported using a paper based reporting system. Staff could describe how to use the system and the types of things that would constitute an incident. Staff told us they received feedback when they reported an incident through team meetings and through daily safety huddles.
- Staff could describe previous incidents and gave an example of a change in practice as a result of lessons learnt. The incident involved images from another hospital not being available for a clinic and caused a delay for patients. A change of practice has resulted in images from other hospitals being requested 24 hours in advance to ensure there were no delays in reporting.
- In the reporting period from April 2015 to March 2016, there had been no never events in outpatients or diagnostic services at the hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between April 2015 and March 2016 there were no incidents categorised as severe reported in outpatients or diagnostic services at the hospital. If a serious incident did occur, there was a process to investigate them using a root cause analysis (RCA) approach and share learning.
- From April 2015 to March 2016 there had been a total of 58 clinical incidents relating to outpatients and diagnostics service. This was approximately 29% of the total number of clinical incidents that were reported at the hospital which is low (good) compared to other independent acute hospitals.
- Staff across outpatients and diagnostics recognised the term 'Duty of Candour'. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw evidence that incidents were investigated and letters of apology were sent out to patients.
- There had been no radiation incidents within the reporting period and managers were aware of their duty of reporting requirements.
- The Hospital managers informed us that they encouraged staff to report all incidents no matter how small and have seen an increase in the reporting of incidents from 317 incidents in 2014/15 to 375 incidents in 2015/16. This was an increase of 18%.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and tidy. We saw completed checklists which indicated that cleaning had taken place.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Hand gel was readily available in all clinical areas and we observed staff using it. Posters displaying hand washing techniques were observed above handwashing sinks.
- Staff could describe the process when patients attended with suspected communicable diseases or requiring isolation including the use of protective equipment and deep cleaning following the procedure.
- Between April 2015 to March 2016 there had been no incidents of Methicillin-resistant Staphylococcus aureus

(MRSA), Meticillin Sensitive Staphylococcus Aureus (MSSA), Clostridium difficile (C.diff), or Escherichia coli (E.coli). We saw infection rates were displayed in the outpatients department to inform patients of their current safety performance with regards to safety performance.

- Hand hygiene audits were completed in line with the world health organisation (WHO) 'five moments of hand hygiene' which describes the key points at which hand hygiene should be completed by health care staff. All areas we visited were compliant in hand hygiene.
- Hand hygiene audits for outpatients and diagnostics department demonstrated 100% compliance for the reporting period from April 2015 to March 2016. We saw that hand hygiene audits were part of the key performance indicators for outpatients and were reported on monthly to ensure compliance.
- Curtains were disposable and appeared to be clean. All curtains we inspected were dated as to when they were changed.
- Infection control meetings took place monthly and were attended by department and senior managers. We saw evidence of monthly infection control meetings and managers confirmed they attended regularly.
- We saw that the hospital had an infection control plan for 2016/17 to further develop staff competence in infection control and ensure the latest guidance was followed.
- We saw evidence of cleaning logs of externally sourced services providing Computerised tomography (CT) scanning (CT) and magnetic resonance imaging (MRI) to ensure that equipment used to provide care and treatment to patients was clean and maintained.

Environment and equipment

- The outpatients department had 10 consulting rooms, a radiology department carrying out x-ray and ultrasound, and a therapy suite which included a fully equipment gymnasium and an audiology booth. Computerised tomography (CT) scanning (CT) and magnetic resonance imaging (MRI) were provided by an external source via a mobile unit.
- There were arrangements in place to control and restrict access to the radiology department and there were electronic signs that displayed if the area was safe to enter.
- Emergency resuscitation equipment was in place in outpatient clinics. The resuscitation trolley we reviewed was visibly clean, and weekly checklists were consistently completed. However, on the days where the mobile scanning units attended the hospital, there was no dedicated resuscitation equipment for its use. We were informed that in the event of a resuscitation emergency, the resuscitation equipment would be taken from the outpatients department. This potentially leaves patients vulnerable should they need urgent resuscitation.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled.
- Equipment observed had stickers which indicated that portable appliance testing (PAT) testing had taken place and was in date. PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. We found two items that required PAT testing. A lamp and a set of scales required re-testing. These were immediately removed by staff to be PAT tested. Following the inspection we saw documentary evidence to support that the service had acted quickly and the items PAT tested.
- Processes were in place to ensure equipment was serviced regularly and faults repaired. We saw documentation to support that all equipment within outpatients, diagnostics and therapy had a regular up to date maintenance schedule.
- There was a small sluice room to service the department. The room was tidy, well presented, and appeared visibly clean.
- We saw evidence that records of authorised registered personnel using the laser equipment was kept and was up to date and the department had two laser protection supervisors.
- Patient-led Assessments of the Care Environment (PLACE) had been completed in 2016. The PLACE audit assesses the quality of the patient environment. The audit found that there were areas for improvement in

the quality of the environment such as there was insufficient space at reception desks so that conversations between staff and patients were not overheard and there was insufficient seating in the waiting areas during busy times. There were plans in place to refurbish the outpatient areas to provide patients with a higher quality environment. We saw from governance meeting minutes that the PLACE audit was discussed and areas for improvement that included improved signage discussed. We were informed that new signage had been ordered.

Medicines

- Medicines were stored securely in a locked cupboard and all were in date.
- No Controlled Drugs (CD's) were dispensed in the outpatients department and there was a policy in place which we found to be reviewed and in date.
- Prescription pads were stored securely and their usage was tracked.
- There was a pharmacy technician on site to support the process of dispensing medication.
- 85% of OPD nursing staff had completed the safe administration of medicines training. This was just below the 90% target.
- Medicines that required storage below eight degrees centigrade were appropriately stored in fridges. Fridge temperatures were generally regularly checked by staff on the ward twice daily. However, we found two dates in June 2016 that fridge temperatures were not recorded.
- The imaging service at Fairfield hospital did not offer nuclear medicine.
- We reviewed 39 patient satisfaction questionnaires for July 2016 and found that 100% of patients were satisfied that they had any side effects to any medication explained to them.

Records

- Patient records were made up of a combination of paper records and electronic records. Paper records were set up for use in each clinic to enable the consultant to record the consultation and any planned treatment. Once the consultation was completed the records were then scanned into the electronic system as a permanent record. The system ensured that all previous appointment records were always available to the consultant.
- Once a patient paper record had been completed they were stored in a central storage away from the department for safety and security.
- Patient files were prepared 24 hours in advance to avoid the potential for delay. Any missing files were investigated and found as a priority.
- From January to March 2016 less than 1% of patients were seen in outpatients without all medical records being available.
- Patient scans that were completed off site were requested 24 hours prior to the appointment to ensure the consultant had the necessary information prior to seeing the patient.
- We reviewed 12 patient records and found that they were mostly complete, legible, and signed and dated appropriately.
- Monthly records audits were completed which took a random sample of 20 patients to ensure that records were completed appropriately. Audit finding showed that outpatients consistently scored above the hospital 90% target from January to March 2016, scoring 98% in March 2016.
- A policy was in place to ensure that consultants did not remove any medical records from the hospital. Managers informed us that consultants did not remove any patient records and this was monitored. Staff we spoke with were aware that records should not to be removed from the hospital site.

Safeguarding

- Safeguarding policies and procedures were in place across the hospital. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. However, we spoke to six staff with regards to Female Genital Mutilation (FGM) and only three were clear on the term FGM, even though managers informed us that FGM was covered as part of the safeguarding mandatory training. We found that FGM was included in the children's safeguarding policy

but was omitted from the adults safeguarding policy. Subsequently, patients who were at risk of FGM may not be properly identified and safeguarding procedures followed. We did however find that all radiology staff and a consultant we spoke to were aware of FGM and the procedures to follow.

- All staff were aware of the process to follow in order to make a safeguarding referral and there was support available if required.
- Safeguarding training was delivered on a rolling 24 month programme. Compliance rates for safeguarding training varied across the department. In outpatients 75% of nursing staff and 90% of healthcare assistants had received safeguarding adult's level 2 training. In radiology and physiotherapy 100% of staff had received safeguarding adult's level 2 training.
- The chief nurse was the safeguarding lead for the Hospital and there was a children's level 4 safeguarding nurse within the hospital. In 2016 the hospital had stopped providing services to children under 16 due to the low numbers of children that required hospital services.
- Children's safeguarding training was undertaken by all staff across outpatients, radiology and physiotherapy. Data provided by the hospital showed that 85% of qualified staff in outpatients, radiology and physiotherapy had completed children's safeguarding level 2, and 100% of health care assistants had completed Level 1 children's safeguarding.
- The Radiology department used the World Health Organisation (WHO) safety checklist for carrying out non-surgical interventional radiology. The aim of the WHO checklist is aimed at improving patient safety by introducing a number of patient safety checks and supports the development of improved team work and communication in radiology. The WHO safety checks were audited monthly and objectives set from the outcomes.

Mandatory training

- Mandatory training was delivered using face-to-face training and e learning.
- Staff received training in areas that included infection prevention, medicine management, consent, data protection, and life support skills.
- Outpatient's mandatory training figures showed in June 2016 they were just below the hospital target of 90% at 87%. In radiology the mandatory training figures were above the hospital target at 96%. Areas of low compliance in training included fire awareness and manual handling. Managers informed us that this was due to having external sources providing this training and this caused delays for staff in receiving the training.
- Mandatory training was not delivered to consultants who worked at the hospital. Their mandatory training was expected to be up to date with their employing NHS trust. However, their mandatory training compliance was confirmed each year to ensure they had the necessary skills and training.
- New consultants at the hospital were required to attend an induction to the hospital which included fire safety and policies and procedures.

Assessing and responding to patient risk

- Staff received training in intermediate life support (ILS) as part of their mandatory training.
- A Resuscitation trolley was easily accessible on the department. We observed records that it was checked weekly and that all the necessary equipment was available.
- Routine observations were not carried out on out the department, however if a patient presented as a concern or deteriorated, then observations of vital signs would be taken. Consultant doctors were available in the department if needed and there was a bleep system for if medical support was required. If a patient's condition deteriorated then staff were required to telephone 999 for transfer to the local NHS hospital. All staff we spoke to were aware of what to do if a patient was to deteriorate on the department.
- For those patients attending the department for pre-operative assessment we saw evidence that patient risk assessments were being completed. These included falls, moving and handling and Malnutrition Universal Screening Tool (MUST) score. We saw that patient risk assessments were completed accurately.
- The department had a radiation protection supervisor and had access to radiation protection advisors via a telephone line for advice and guidance, and to ensure that there is adherence to the safe working practices.

Good

Outpatients and diagnostic imaging

- There was electronic signage in the radiology waiting area to inform patients that radiation exposure was taking place. We observed that the electronic signage was in working order.
- The department used twice daily safety huddles to disseminate information across the team. The information included any important patient safety information including support required.

Nursing staffing

- The outpatients department displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements.
- The department manager undertook a weekly review of clinic activity to ensure the department was appropriately staffed.
- Across the outpatient department there were a total of 10.7 trained nursing staff and 4.4 healthcare assistants.
- Radiology was staffed with five radiographers which equalled two whole time equivalents and one healthcare assistant and one admin support worker.
- The Therapy suite had nine physiotherapists which equalled three whole time equivalents and a secretary. The service also had three part time occupational therapists to complete assessments; this was equal to less than one whole time equivalent.
- There was one vacancy for a qualified nurse on the outpatients department. All other areas were fully staffed.
- The department used bank or agency staff to fill staff shortages due to sickness and annual leave. In the reporting period from April 2015 to March 2016 the use of bank or agency staff was low and remained below the average 5% of other independent hospitals.
- There were no unfilled shifts between January 2016 to March 2016.
- Sickness rates were mainly higher than the yearly average of other independent acute hospitals; however, in March 2016 the sickness levels fell back to 0%. Managers informed us that sickness had been higher than normal due to a number of staff being off due to needing surgical procedures and being off work for extended periods of time.
- There was no staff turnover within outpatients and diagnostics within the reporting period from April 2015 to March 2016.

Medical staffing

- There were 10 consulting rooms within outpatients. Appointments were booked in advance to ensure that each consultant had use of a consulting room and there were enough nursing staff to provide support to the consultants. For each consultant there was one member of the nursing team for support.
- In radiology there were eight consultant radiologists who reported within their sphere of expertise. For example, the Breast Radiologist reported on all breast radiology.
- All the consultants were employed by the NHS and worked at the hospital under practicing privileges. Practicing privileges is the grant of a person managing the hospital to a medical practitioner, to permission to practice as a medical practitioner in that hospital.

Major incident awareness and training

- The hospital had a major incident policy which listed key risks that could affect the provision of care and treatment. Staff members were aware of the policy and knew how to access this in the event of an emergency.
- The hospital had backup generators in case of power supply to ensure services were not affected.
- Staff were aware of the procedures they were to follow in the event of a fire.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

At present we do not rate effective for outpatients and diagnostic imaging services in acute independent hospitals. However, during our inspection we noted the following;

Good

Outpatients and diagnostic imaging

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- The Radiology department had implemented the World Health Organisation (WHO) safety checklist for non-surgical interventional radiology. The safety checklist was audited every three months to evaluate the efficacy of the checklist. The audit completed from May to July 2016 provided findings and objectives to improve performance.
- Magnetic resonance imaging (MRI) was provided by an external source via a mobile unit on a weekly basis. The external provider participated in the Imaging Services Accreditation Scheme (ISAS) licenced by the Royal College of Radiologists. (ISAS) is a patient-focussed assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- Staff were supported in their development using the appraisal process, which was undertaken annually. 100% of nursing and healthcare staff across the outpatients and diagnostics department had received an annual appraisal in 2016.
- Consultants at the hospital were only granted practicing privileges once approved by the Medical Advisory Committee (MAC).
- Radiologists maintained an on call rota 24 hours per day, 7 days per week.
- All staff (100%) on the OPD had completed training in consent and mental capacity act. Within radiology and therapy 90% of staff had completed mental capacity act training and 100% of staff had completed the consent training.

However,

- Consent forms were not always completed in full. We looked at 10 consent forms and found in four consent forms there were omissions in the completeness of the form which included documenting, gender, staff job title and date.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).

- Staff had easy access to the all the hospital policies and procedures using the ward computers. All staff were aware of where policies and procedures were stored.
- We saw that the computer system shared drive provided nursing staff with evidence based practice protocols and proformas to follow for standardising clinics pre-operative patient consultations. This ensured that each clinic had the right equipment and information available to the consultant and informed staff of procedures to follow.
- We saw evidence of pathways for different treatments that were to be followed. These included pathways for patients suspected of having a deep vein thrombosis, acute kidney injury or sepsis.
- The hospital had an audit plan that set out for the year the audits to be completed for 2016. These included pre-operative assessment to ensure compliance with NICE guidelines. We saw from the audit completed in February to March 2016 that action plans had been drawn up that included pre-operative assessments for patients requiring cataract surgery need to take place at the hospital and not via the telephone to meet with NICE guidelines.
- The Radiology department had implemented the World Health Organisation (WHO) safety checklist for non-surgical interventional radiology. The safety checklist was audited every three months to evaluate the efficacy of the checklist. The audit completed from May to July 2016 provided findings and objectives to improve future performance.
- Staff working in radiation areas wore personal radiation monitoring devices or dosimeters (PMDs). The PMD's detect various forms of radiation a worker may be exposed to. The dosimeter or badge detects the exposure of a person to x-rays, gamma radiation, neutron and beta particles. We saw that staff were required to wear the PMD's. Accumulated doses from the various types of radiation was measured by the dosimetry service provider and was reported back to the hospital.

Pain relief

- There were processes in place to assess patient's pain levels and act appropriately. We saw from therapy records that pain scores were part of the assessment process.
- We reviewed 39 patient satisfaction questionnaires from July 2016 and 100% of patients reported that if they suffered pain it was adequately controlled. From the questionnaires, 100% of patients also reported that side effects of any medication was explained to them.

Patient outcomes

- There were local audit programmes for outpatients, radiology and physiotherapy, with monitoring arrangements in place to review findings. Audits included auditing of patient records, MRSA and hand hygiene. From the patient records audits completed in January to March 2016, OPD averaged 97% compliance against a hospital target of 90%. The monthly audit examined 46 separate key details that included whether consent, allergies and treatment plan had been recorded.
- The Therapy service used the Bournemouth questionnaire, which is a patient self-reporting questionnaire that consists of seven core items, such as pain intensity and function in activities of daily living. The questionnaire asked patients to rate from one to ten against the seven core items to give a total out of 70. The questionnaire was completed pre and post intervention to measure patient scores across the seven areas. The full audit outcomes was due in August 2016, however from the evidence supplied by the department it was clear to see that patient scores improved following physiotherapy intervention. For example, we reviewed Bournemouth score data from January to July 2016 pre and post intervention, and found that only one patient self-reported that their score against the Bournemouth scale was higher post intervention.
- Magnetic resonance imaging (MRI) was provided by an external source via a mobile unit on a weekly basis. The external provider participated in the Imaging Services Accreditation Scheme (ISAS) licenced by the Royal College of Radiologists. (ISAS) is a patient-focussed assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments).
- Audits of the WHO interventional radiology safety checklist showed that areas of improvement required patient safety and experience. One objective from the audit was staff were to ensure that every patient is aware of the procedure before leaving the department prior to appointment and has the correct information leaflets. The audit found that out of 81 checklists completed only 6 patients had a lack of knowledge or information prior to the procedure taking place.
- The imaging service audited the diagnostic reference levels as an aid to optimisation of medical exposure. The actions from the audit included further reducing radiation doses to enhance patient safety. The audit finding from January 2014 to January 2015 found that there had been a sustained decrease in the radiation dose given to patients since using a new image intensifier.
- The imaging service carried out audits where radiation from medical exposure had the capability to cause harm to an unborn child. The aim of the audit was to ensure that the pregnancy status of women of child bearing age had been documented. The audit from 1 April to 20 June 2016 looked at 30 random sets of documentation to ensure that there was documentation of last menstrual period (LMP) that included an LMP date, clear indication that the patient had been asked about LMP, authorising signature and evidence that the sticker used in patient records to indicate LMP was being considered. The audit found that although there was general compliance there were some omissions in the records sampled. We saw that an action plan had been developed that included a re-audit and further staff training.

Competent staff

- Staff were supported in their development using the appraisal process, which was undertaken annually. 100% of nursing and healthcare staff across the outpatients and diagnostics department had received an annual appraisal in 2016.
- All qualified staff within the radiography department were registered with the Health professions Council (HPC) and maintain their registration with regular continuing professional development. A record of all professional development activities for each radiographer was kept on their personnel file on the department.

- Clinical supervision was provided to all trained staff on a three monthly basis. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on, and discuss their work and their personal and professional responses to their role.
- The OPD manager had a mentor at Southport and Ormskirk hospital to provide up to date practices within OPD services.
- OPD had one staff nurse who was a mentor for student nurses and another nurse had enrolled to become a mentor. At the time of inspection there were no student nurses within the department.
- Consultants at the hospital were only granted practicing privileges once approved by the Medical Advisory Committee (MAC). Consultants were only authorised to operate within their scope of practice and had to provide evidence to the MAC of any specialist training that they have received. This ensured that consultants only carried out treatments, procedures or reporting within their scope of training.
- The hospital contributed towards a whole system appraisal for consultants, and kept logs of complaints, compliments, incidents and adverse events for each consultant to inform their NHS employer.
- Staff were provided with relevant information throughout the day via daily safety huddles. These safety huddles provided staff with information about highlighted risks and things to remember and any shared learning from incidents and complaints. We saw evidence that safety huddles were being completed daily.

Multidisciplinary working (related to this core service)

- The diagnostic imaging, therapies and outpatients departments were staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.
- We observed nurses and therapists working alongside consultants. Interactions were positive and professional.
- All outpatient clinics were consultant led and did not employ specialist nurses. Referral to specialist nurses in the community could be made if required for patients.
- To ensure imaging resources taken at another location were available at the time of appointment, clinic information was reviewed at least 24 hours in advance to ensure all images and scans were available to the consultant.
- To ensure that there were no delays in reporting of imaging, the radiology department would ask the next visiting radiologist to complete the reporting to avoid any delays to the patients. Ultrasound scans and fluoroscopy scans are reported on the same day as the examination.
- We observed positive working relationships between managers and the staff groups. We observed managers across the department to have close professional relationships with the staffing groups and provided them with advice and guidance as required.

Seven-day services

- Outpatients provided a six day service and clinics ran from 8am through to 8pm from Monday to Friday and 8am to 2pm on a Saturday.
- Radiologists maintained an on call rota 24 hours per day, 7 days per week.

Access to information

- The radiology department used a nationally recognised system to report and store patient images. The system used allowed local access to images. Previous images could also be viewed by staff. Any images taken in other hospitals required staff to request them. The hospital staff requested these 24 hours in advance to ensure they were available to view during consultation. Staff we spoke to were aware of the process of requesting images in advance.
- Staff told us that appointments were not cancelled due to unavailability of records as a temporary record could be used. Previous investigation results and letters were available electronically for patients attending a follow up appointment.
- From April to June 2016 there were less than 1% of patients who were seen in outpatients without all the relevant records being available.
- To ensure that the paper records are always available, they were stored securely off the department. Written guidance enforced that consultants and staff were not able to remove records from the hospital and was audited as part of the hospital's quality certificate.
- Discharge letters were sent to patient's GP's electronically to provide a summary of treatment or investigation. Audits were completed to ensure that the service monitored and improved the delivery of discharge letters to GP's. Audits for March 2016 prior to the start of electronic records reviewed 100 patient

discharge letters and found that only seven discharge letters had not been sent to the GP within seven days following attendance for a procedure and discharged back to the GP from Outpatients clinic.
- Policies and procedures were available on the hospital shared hard drive and staff were aware of how to access them. We saw that policies and procedures had been reviewed and were updated.
- We observed that each nursing station and consulting room had access to the hospital computer system.
- We saw noticeboards in the nursing base stations, therapy room and radiology room that displayed important safety information and current incident reporting statistics.
- Information from team meetings was e-mailed to staff and displayed in staff areas to read and sign. This ensured that all staff had access to the latest information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed ten patient records that required a surgical procedure, and found that consent to the procedure had been documented in all records. Consent was also confirmed on the day of the surgery and this was documented in all the records we reviewed. However, although all consent forms had been signed, not all consent forms had been completed fully. In four consent forms we found there were omissions in the completeness of the form which included documenting, gender, staff job title and date.
- Staff we spoke to knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care. Staff understood the application of considering capacity, consent and deprivation of liberty.
- All staff (100%) on the OPD had completed training in consent and mental capacity act. Within radiology and therapy 90% of staff had completed mental capacity act training and 100% of staff had completed the consent training.
- The hospital completed a consent audit in May 2016 and found that consent was appropriately recorded in 98% of records against a hospital target of 95%.

Are outpatients and diagnostic imaging services caring?

Good

We rated Outpatients and Diagnostic imaging as 'Good' for Caring because;

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. We observed how staff interacted with patients and their families and found them to be polite, friendly and helpful. We saw that staff introduced themselves and acted in a courteous and professional manner.
- From the 39 patients satisfaction questionnaires we reviewed for July 2016, 100% of patients were satisfied with the greeting they received on entering the department.
- Chaperones were available for all consultations if they were required. We saw that when a chaperone had been used then this was stamped into the patient's records. Chaperones were always present for those patients requiring an intimate examination or procedure.
- Patient identified with complex needs were able to wait in a quiet room if preferred with the aim to be seen as quickly as possible.
- From the 39 patient satisfaction questionnaires completed all (100%) reported that when they had important questions to ask they had information they could understand.
- We observed consultants and nursing staff spending time with patients to provide them with the necessary reassurance of their care and treatment. Six patients we spoke to who informed us the risks and benefits of treatment had been explained, pain was discussed and controlled, and staff were very thorough.

Compassionate care

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. We observed how staff interacted with patients and their families and found them to be polite, friendly and helpful. We saw that staff introduced themselves and acted in a courteous and professional manner.
- From the 39 patient satisfaction questionnaires we reviewed for July 2016, 100% of patients were satisfied with the greeting they received on entering the department.

Good

Outpatients and diagnostic imaging

- We spoke with six patients and their views were positive. Patients reported that staff were polite and professional, they felt welcomed and they had been listened to.
- The Hospital took part in the NHS friends and family survey, which assesses whether patients would recommend a service to their friends and family. The latest results from May 2016 showed that 93% of patients who took part were extremely likely to recommend the outpatients service. Another 6% reported they were likely to recommend and the remaining 1% reported they didn't know if they would recommend the outpatient services.
- From the questionnaires we reviewed the comments made by patients were all positive. Patients reported that they had excellent treatment from consultation to operation, and staff were friendly and put patients at ease.
- Chaperones were available for all consultations if they were required. We saw that when a chaperone had been used, this was stamped into the patient's records. Chaperones were always present for those patients requiring an intimate examination or procedure.

Understanding and involvement of patients and those close to them

- There were many family groups in all areas inspected. These could accompany patients if required.
- Patient identified with complex needs were able to wait in a quiet room if preferred with the aim to be seen as quickly as possible.
- We saw positive interactions between staff, patients and those close to them.
- All outpatient appointments we observed during the inspection ran on time; however staff were able to explain that for any reason an appointment was running late they would explain this to the patient immediately to keep them and their relatives informed.
- From the 39 patient satisfaction questionnaires completed all (100%) reported that when they had important questions to ask they had information they could understand.
- Appointments were scheduled by consultants that included time for patients to ask questions following their consultation. From the patient questionnaires completed for July 2016, 100% of patients and their relatives reported that they were involved as much as they wanted.
- Patients who were paying for their treatment were informed of the costs prior to consultation. The hospital website also displayed the costs of treatment in order for patients to be prior informed of costs.

Emotional support

- We observed that there were leaflets available that were handed to patients to explain and understand their care, treatment and condition. Leaflets were provided in English language; however staff were able to request information in differing formats if required.
- From the 39 patient satisfaction questionnaires completed all (100%) reported that they received the right amount of information about their condition.
- Consultants were able to refer patients for specialist advice if needed in the community to support patients with their emotional needs.
- We observed consultants and nursing staff spending time with patients to provide them with the necessary reassurance of their care and treatment. Six patients we spoke to who informed us the risks and benefits of treatment had been explained, pain was discussed and controlled, and staff were very thorough.
- Information was displayed on the department so that patients could source help from other professionals if required such as Dementia UK.

Are outpatients and diagnostic imaging services responsive?

Good

We rated Outpatients and Diagnostic imaging as 'Good' for Responsive because;

- There was free car parking at the hospital for patients and visitors with an over spill car park for those attending at the busiest times.
- Patient waiting areas appeared clean and the atmosphere relaxed and reading material was available for patients whilst waiting.
- Free tea and coffee and water coolers were available across the department so patients could help themselves. Vending machines were also present to purchase items if required.
- Information sent to patients was sent to them in formats to meet their individual needs. Referrals from the initial

source highlighted special circumstances to enable the hospital to respond appropriately For example if patients required information in another format then this could be arranged. I.e. large font text for those people with sight impairment.

- Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs. Clinic times were available up to 8pm on week days and clinic appointments were available on a Saturday to meet the needs of the patients.
- The department audited patient waiting times to ensure patients were seen within 30 minutes. The hospital target for 30 minute waiting times was 90%. From January to June 2016, outpatients had exceeded this target. In June 2016 the department saw 95% of patients within 30 minutes.
- The department had developed a text reminding service to decrease the number of did not attend (DNA) rates. A simple text reminder was sent to patients one week prior to appointment and then again two days before to minimise the number of patients who did not attend. Since this service was introduced in late 2015 the hospital had seen its DNA rate fall from 5% to 3% in 2016.
- A symbol was used in patient records to identify those patients who were living with dementia to ensure patients received the support they required.
- The Hospital had a total of 39 complaints within the reporting period from April 2015 to March 2016. This is considered low in comparison with other independent acute hospitals.
- Information regarding patients' needs were captured using patient satisfaction questionnaires. These were routinely collated daily to help inform service delivery. The hospital carried out a review of patient comments and had initiated improvements to the Wi-Fi from comments raised by patients.

However,

- Within the outpatient areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. They were only in English but could be ordered in other languages or alternative formats if required. However, we observed that some of the patient leaflets were out of date and needed to be reviewed to ensure that they contained the latest information for patients.

Service planning and delivery to meet the needs of local people

- We observed clear signposting through the hospital to the outpatients and diagnostic imaging departments to support patients in locating the right clinic area.
- Patient waiting areas appeared clean and the atmosphere relaxed and reading material was available for patients whilst waiting.
- Patients told us they received instructions with their appointment letters and were given written information, as needed. We reviewed information sent out to patients and found that clear information was sent to patients with instructions on how to find the hospital.
- There was free car parking at the hospital for patients and visitors with an over spill car park for those attending at the busiest times.
- There was wheelchair access throughout the outpatients department.
- We observed that there was sufficient seating in waiting areas. However, staff told us the waiting areas could become 'cramped' at the busiest times.
- Patient waiting areas had access to unisex toilets. There were two toilets to service the whole department.
- Free tea and coffee and water coolers were available across the department so patients could help themselves. Vending machines were also present to purchase items if required.
- Information sent to patients was sent to them in formats to meet their individual needs. Referrals from the initial source highlighted special circumstances to enable the hospital to respond appropriately. For example if patients required information in another format then this could be arranged. e.g. large font text for those people with sight impairment.
- Information regarding patients' needs were captured using patient satisfaction questionnaires. These were routinely collated daily to help inform service delivery. The hospital carried out a review of patient comments and had initiated improvements to the Wi-Fi from comments raised by patients.

Access and flow

Good

Outpatients and diagnostic imaging

- There were 47,347 attendances to outpatients between April 2015 and March 2016.
- Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs. Clinic times were available up to 8pm during the week.
- Arrangements were in place to support patients who required next day appointments; however this was dependent on the availability of the specialist consultant.
- The department aimed to see patients within 30 minutes of arrival to the department. Waiting times were not displayed, however nursing staff kept patients informed of any delays in being seen. During the inspection we did not find any appointments that were late.
- The department audited patient waiting times to ensure patients were seen within 30 minutes. The hospital target for 30 minute waiting times was 90%. From January to June 2016, outpatients had exceeded this target. In June 2016 the department saw 95% of patients within 30 minutes.
- The department met the referral to treatment standard of 95% for non-admitted pathways from April 2015 to March 2016. For the whole reporting period the referral to treatment waiting times were above 95%. Non-admitted pathways means those patients whose treatment started during the month and did not involve admission to hospital.
- The department met the national standard of 92% for referral to treatment rates each month for incomplete pathways between April 2015 to March 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- The department had developed a text reminding service to decrease the number of did not attend (DNA) rates. A simple text reminder was sent to patients one week prior to appointment and then again two days before to minimise the number of patients who did not attend. Since this service was introduced in late 2015 the hospital had seen its DNA rate fall from 5% to 3% in 2016.
- In the radiology department report turnaround times were audited to ensure imaging information was shared quickly. The department achieved above the 90% target from April to June 2016 with an average compliance rate of 96% in the period.
- For urgent reports that required to be reported within two to five days the department achieved an average urgent turnaround time of 96% from April to June 2016 against a target of 100%. The department had only achieved 89% in April 2016. However, in May and June 2016 the department achieved 100%. We saw documentary evidence that the department monitored its performance as part of its key performance indicators.
- Referrals to other departments within the hospital, for example, to the therapy team were paper-based referrals. These were completed by the referring consultant and then passed to the therapy team for triage. Appointments could be made whilst the patient was at the hospital at a time to suit their needs.
- The hospital made provision to offer clinical assessments in the patients' home. For example, the occupational therapists offered pre-operative home visit assessments prior to joint replacement surgery.

Meeting people's individual needs

- The administration team upon receiving a referral would determine if a patients needs could be met at the outpatient and diagnostics department. This was to ensure that the needs of those patients attending a clinic could be met. Any patients with complex needs, for example multiple complex medical health problems that could not be met at the clinic would be signposted back to the referrer to be seen at the local NHS trust hospital.
- Access to interpreting services could be arranged by telephone for those patients whose first language was not English.
- For patients whose first language was not English, face to face translators could be booked in advance. We did not see this system in use, as we did not observe any patients requiring translation services during our inspection. Staff were able to explain the process they would follow if translation services were required.
- A hearing loop system was available for those patients that were hard of hearing.

Good

Outpatients and diagnostic imaging

- Within the outpatient areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. They were only in English but could be ordered in other languages or alternative formats if required. However, we observed that some of the patient leaflets given to patients were out of date and needed to be reviewed to ensure that they contained the latest information for patients.
- There were bariatric outpatient facilities, such as wider chairs if required, and in radiology there was systems in place to ensure images could be taken.
- The waiting areas in the main outpatients included standard seating. However there was no raised seating observed. This meant the seating might not be suitable for some patients with mobility difficulties.
- The layout of the reception desks and waiting areas meant that there was no space for a privacy line and conversations could easily be overheard. Reception staff were polite and friendly and if patients preferred not to confirm details verbally, they could be written down, to protect confidential information or they could discuss their details confidentially away from the reception desk.
- For those patients who were of child bearing age. It was required by staff to ask if they could be pregnant and their last menstrual period was documented. A sticker was placed in the patient notes to document the date of late period and to record if the patient was pregnant. Staff were aware of this process and were able to demonstrate the use of the procedure to follow.
- A symbol was used in patient records to identify those patients who were living with dementia to ensure patients received the support they required. The department had coloured toilet seats, and we were informed by managers that new signage had been ordered for the toilet doors to help support those patients living with dementia. We saw from governance meeting minutes on the 31 March 2016 that this had been raised and discussed following a patient led assessment of the care environment (PLACE) audit that had taken place.
- For those patients who required extra support, the department aimed to see them quickly. If prior notice was given the patient was offered the first or last appointment to ensure they were seen without delay.
- Clinic appointments were provided six days per week, from 8am through to 8pm from Monday to Friday and 8am to 2pm on a Saturday to ensure there were appointment times to suit most patients' individual needs.
- Consultants decided on the length of appointments that a patient required. We saw from the waiting times that no clinics ran over schedule that these appointment times were appropriate to the patient needs. Patients we spoke to confirmed that they were satisfied with the service they had received. We reviewed 39 patient satisfaction questionnaires from July 2016 and 100% of patients reported that they received the right amount of information about their condition.
- Transport services were not offered by the hospital and relied upon the patient booking transport through the 'choose and book' service.
- The hospital had a diversity and strategy that was issued in January 2015. Staff we spoke to were aware of how to access the policy document on the hospital computer shared drive.

Learning from complaints and concerns

- The hospital had a complaints policy that had been reviewed in February 2015. Staff and managers were aware of the policy and where to find it using the hospital electronic shared drive.
- Initial complaints were dealt with by clinic managers in the outpatients department in an attempt to resolve issues locally. However, if this could not be resolved then the complaint would be escalated to the senior management team.
- The chief executive was the individual responsible for overseeing all complaints within the hospital. This included initial acknowledgement, investigation and final response.
- The Hospital had a total of 39 complaints within the reporting period from April 2015 to March 2016. This is considered low in comparison with other independent acute hospitals.
- The hospital aimed to acknowledge the complaint within two days of receipt and to have a final response within 20 days. Of the 39 complaints only three had not been completed in accordance to the timeframe of the policy.

Good

Outpatients and diagnostic imaging

- We saw from the complaints log from December 2015 to May 2016 actions had been taken to improve future performance and to minimise the reoccurrence of a complaint. Actions included monitoring staff performance and re-training.

Are outpatients and diagnostic imaging services well-led?

Good

We rated Outpatients and Diagnostic imaging as 'Good' for Well-led because;

- The hospital had a set out a strategic plan for 2015 to 2020 that incorporated a mission and a vision for the hospital.
- Staff were aware of the hospital vision and were aware of the future development changes in the department that included a refurbishment.
- Managers of the department attended clinical governance meetings on a monthly basis and we saw that minutes of these meetings were available.
- Staff reported on risk, incidents, and complaints and information was cascaded back to staff via daily safety huddles and team meetings. Information was also disseminated by e-mailing the staff teams to ensure all staff had the latest information. We saw that minutes of team meetings were kept and staff confirmed that meetings took place.
- The department had taken action to ensure that local safety procedures were in place in radiology to ensure patient safety. The department used the WHO interventional radiology safety checklist and audited the findings.
- The hospital had a risk register which highlighted risks associated with the daily operation of the hospital. We saw that risks had been identified and actions taken to mitigate the risks in a number of areas that included staffing, medicine management, infection control and consent procedures.
- Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. We were informed that all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC) chairperson for approval. Consultant documentation was reviewed on a quarterly basis and performance certificates issued every two years for consultants practicing in the NHS. Information was kept with regards to compliments, complaints, and incidents to help inform the appraisal system.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Staff from OPD and radiology told us that managers of the service were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.
- In the 2015/16 staff survey, 97% of staff employed in the reporting period who recommend the hospital as a provider of care to their friends and family.
- Results from the 2015/2016 patient satisfaction questionnaire showed that 100% of patients would recommend the hospital to a friend or family member and 99.55% would rate the overall standard as very good or excellent.
- Managers were aware of their current performance and through monthly meetings discussed how performance would be improved. We saw from governance meeting minutes that improvements or non-compliance was discussed and areas of improvement identified.

However,

- Risk assessments were completed by department managers and RAG rated from Red to Green. A risk matrix was used to score the severity of the risk. A score above 15 should be highlighted to the senior management team for consideration for inclusion on the hospital risk register. However we found that the calculation of risk severity using the risk matrix was not always completed accurately meaning that some department risks were not being highlighted to the senior management team. We found a total of eight risks assessments from a total of 22 that had a risk score of 15 that were not highlighted on the hospital risk register or may have been miscoded.
- Not all risks relating the department had been completed and level of risk mitigated. We found that the use of the resuscitation trolley by the mobile scanning service had not been risk assessed or written action put

into place to mitigate the risk if a patient required resuscitation. We were informed that the contingency plan was to use the resuscitation trolley from another department upstairs.

Vision and strategy for this this core service

- The hospital had a set out a strategic plan for 2015 to 2020 that incorporated a mission and a vision for the hospital; the mission was to improve the health and quality of life for the people of North West England through the provision of a high quality and affordable independent Hospital services.
- The vision was to provide a high quality medical facility with highly trained and motivated staff with the latest and best medical equipment in a safe and sustainable environment. The outpatients and diagnostics department had aligned their practices to ensure that the mission and values were encompassed into the practice. We found that Staff were well trained and highly motivated to ensure patient safety and the equipment being used was serviced regularly and operated by trained professionals.
- Staff were aware of the hospital vision and were aware of the future development changes in the department that included a refurbishment.

Governance, risk management and quality measurement for this core service

- Managers of the department attended clinical governance meetings on a monthly basis and we saw that minutes of these meetings were available.
- Staff reported on risk, incidents, and complaints and information was cascaded back to staff via daily safety huddles and team meetings. Information was also disseminated by e-mailing the staff teams to ensure all staff had the latest information. We saw that minutes of team meetings were kept and staff confirmed that meetings took place.
- The hospital had a risk register which highlighted risks associated with the daily operation of the hospital. We saw that risks had been identified and actions taken to mitigate the risks in a number of areas that included staffing, medicine management, infection control and consent procedures.
- Risk assessments were completed by department managers and RAG rated from Red to Green. A risk matrix was used to score the severity of the risk. A score above 15 should be highlighted to the senior management team for consideration for inclusion on the hospital risk register. However we found that the calculation of risk severity using the risk matrix was not always completed accurately meaning that some department risks were not being highlighted to the senior management team. We found a total of eight risks assessments from a total of 22 that had a risk score of 15 that were not highlighted on the hospital risk register or may have been miscoded.
- The use of the resuscitation trolley by the mobile scanning service had not been risk assessed or action put into place to mitigate the risk if a patient required resuscitation. We were informed that the contingency plan was to use the resuscitation trolley from another department upstairs.
- The department had taken action to ensure that local safety procedures were in place in radiology to ensure patient safety. The department used the WHO interventional radiology safety checklist and audited the findings. Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. We were informed that all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC) chairperson for approval. Consultant documentation was reviewed on a quarterly basis and performance certificates issued every two years for consultants practicing in the NHS. Information regarding each consultant was kept with regards to compliments, complaints, and incidents to help inform the appraisal system.
- We saw that there was a valid, recently reviewed terms of reference for the MAC to ensure the function of the MAC took place with clear roles and responsibilities set out. These included to support and advise the hospital in order to help provide a safe and secure clinical environment and to review the hospital Key Performance Indicators (KPI's).
- The MAC met quarterly. We reviewed MAC meeting minutes from March 2016 and saw that practicing privileges, adverse events, complaints, and audits were discussed.
- KPI's were set for outpatients and diagnostics to monitor performance in key areas and found that areas for monitoring included documentation, training, waiting times and report turnaround times. There were four KPI's for radiology and five for outpatients, one of which was whether a team meeting had taken place. Senior managers informed us that they needed to

monitor team meetings as this was essential for the dissemination of information across the hospital. We saw that monthly auditing took place to review performance against the hospital targets of the KPI's and cascaded back to the staff teams.

- The department had service level agreements (SLA's) with several different organisations. These organisations provided services to the hospital to ensure the hospital was able to function. These services included MRI and CT scanning, laundry, pathology and medical equipment maintenance. We saw that contracts were in place and review dates documented.
- There was security arrangements on site 24 hours per day. At night two night porters provided security to patients and staff.

Leadership / culture of service

- In the 2015/16 staff survey, 97% of staff employed in the reporting period who recommend the hospital as a provider of care to their friends and family.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- All staff told us that managers of the service were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.
- All staff we spoke to told us they were content in their role and many staff had worked at the hospital for many years. The turnover rate of 0% for OPD for the reporting period from April 2015 to March 2016 supported that staff were content in their role.
- Staff felt they could approach managers with concerns including the senior management team and their views would be listened too. Staff we spoke to had no concerns at the time of inspection and reported that they felt valued and appreciated.
- We saw good, positive, and friendly interactions between staff, managers and the senior management team.
- The managers of the outpatients, radiology and therapy services were visible in the departments and we observed a supportive management culture.
- Staff described the culture at the hospital as being open and honest. Staff reported that working at the hospital was like 'one big family'.
- Training, support and monitoring took place to ensure staff had the skills and training they required to fulfil their role. Staff told us that the senior management team were often on the department to offer advice and support this included the chief executive. We observed that the chief executive knew the staff on the department by name and interactions were positive. In the 2015 staff survey, 82% of the staff would recommend the hospital as a place to work. The average response rate over the reporting period was 60% which was a large increase from the 47% in 2013.

Public and staff engagement

- The views of patients were actively sought within outpatients and diagnostic imaging using the NHS Friends and Family Test (FFT) and patient satisfaction questionnaires. Results from the FFT for NHS funded patients showed that in the reporting period April 2015 to March 2016, the hospital scored 100%, with the exception of March 2016 where the score dropped to 92%, when patients were asked how likely they were to recommend the hospital to family and friends. The response rate was consistently above the England average for the whole reporting period.
- The patient satisfaction questionnaires were reviewed on a daily basis by the chief executive. We were informed that they were reviewed daily to ensure that any problems identified by patients were immediately rectified. We saw from letters written by the chief executive to patients that any identified issues were quickly expedited.
- Results from the 2015/2016 patient satisfaction questionnaire showed that 100% of patients would recommend the hospital to a friend or family member and 99.55% would rate the overall standard as very good or excellent.

Innovation, improvement and sustainability

- The department had a number of new initiatives to continue to improve patient services. For example, patients requiring a diagnostic bladder examination were now seen in the outpatient clinics instead of being on a day case ward environment. This provided patients with the opportunity to discuss the findings from their diagnostic procedure with their Consultant, leaving the

appointment with a personal treatment plan or discharged back to their GP with any concerns addressed. The outpatient department had also established a similar service for joint injections.

- The hospital strived to improve services for its patients. There was a board of trustees with a duty to ensure that the organisation makes continuous improvements and all staff we spoke to were aware of the plans to improve the environment in the outpatients department.
- Managers were aware of their current performance and through monthly meetings discussed how performance could be improved. We saw from governance meeting minutes that service improvements or areas of service non-compliance was discussed and actions needed.
- The department was due to be refurbished to include an improved reception and waiting area to improve flow in outpatients and enhance patient experience.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should take action to address that not all staff are aware of the policy with regards to female genital mutilation (FGM). FGM should form part of the adult safeguarding policy and not just the children's safeguarding policy.
- The hospital should take action to ensure all consent forms are fully completed.
- The hospital should take action to provide leaflets to patients that are regularly reviewed, and in date with the latest information.
- Risk assessments should be scored appropriately and where necessary escalated to the senior team.
- Risk assessments for the department should be reviewed to ensure that all areas of the service are considered so that risks can be mitigated, and actions put in place to reduce the impact and severity.
- The hospital should consider patients privacy on booking in to the department as there was no privacy line.
- The hospital should consider providing seating for those patients with mobility difficulties.
- The management team should make sure that all consultants sign to confirm final site marking verification during the 'sign in' phase of the WHO checklist.
- The hospital is in the process of becoming JAG accredited for endoscopy services and this is planned for May 2017. The hospital should ensure that the implementation plan is achieved.
- The hospital should ensure that all mandatory training for staff is completed in a timely manner and meets the hospital compliance target as a minimum.