Mount Stuart Hospital

Quality Report

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Date of inspection visit: 25 to 26 June 2018
Date of publication: 08/10/2018

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?	
Are services responsive?	
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Mount Stuart Hospital is operated by Ramsay Health Care.

This inspection was a follow-up to our 2016 inspection and we only looked at areas previously found to need action.

We carried out a comprehensive announced inspection of Mount Stuart Hospital on 6 and 7 September 2016, and an unannounced inspection on 15 September 2016. We found that safety, effectiveness and well-led had areas for improvement and breaches were found under four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An extensive action plan was provided by the service to meet those areas and it is recognised that significant improvements have been made.

We inspected surgery and outpatients under the domains of safe, effective and well-led. We did not inspect any elements of caring or responsive.

Surgery, and outpatient and diagnostic services are provided at the hospital. Day case and inpatient surgery specialities included general surgery, major and minor orthopaedic surgery, ophthalmology, ear nose and throat surgery, gynaecology, urology, dermatology, endoscopy and cosmetic surgery.

The hospital has 26 single room inpatient beds of which 23 are currently in use and 12 ambulatory care spaces. There are three main operating theatres each with air flow systems suitable for their use, one day case theatre, and a recovery area.

Outpatient and diagnostic services are delivered in consulting rooms and include orthopaedics, general surgery, gynaecology and obstetrics, cosmetic surgery, ear nose and throat, urology, oral and maxilla, ophthalmology, gastroenterology, dermatology, and facial surgery.

Diagnostic imaging services include plain x-ray, ultrasound, and fluoroscopy, magnetic resonance imaging (MRI) and computed tomography (CT) is provided from a mobile unit. There was a private physiotherapy service for outpatient and inpatient services. Non-surgical cosmetic treatments are delivered by the cosmetic suit.

We inspected this service using our inspection methodology. We carried out an unannounced visit to the hospital on the 25 and 26 June 2018.

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

Services we rate

We rated this hospital/service as good overall.

- Staff were suitably skilled to meet the needs of the patients. Mandatory training was provided for all staff and monitored to ensure all staff remained suitably skilled and updated. Staffing was planned and managed to ensure sufficient staff were available. Staff were appraised to ensure they had the skills, knowledge and experience to deliver effective care.
- Systems were followed to ensure cleanliness of the departments and promote infection control. The arrangements for managing waste in the hospital environment kept people safe. The systems and processes to manage the environment and equipment kept patients safe.
- Patients were suitably assessed and systems were provided to respond to risks to ensure patient safety. Risk assessments were completed to measure and manage patient risks. The safeguarding systems and processes ensured patient safety.

Summary of findings

- Care and treatment was provided using best practice standards and evidence based guidance. Management of medicines was safe. The nutritional needs of patients were reviewed, assessed, monitored and met and patients' pain was assessed and managed to ensure patients were comfortable.
- The outcomes of patients' care and treatment were collected and monitored to measure the quality of the service provided. Incidents were recorded and reviewed to provide learning and prevent reoccurrence.
- Staff worked well between departments and with external services. Patient records were well maintained and stored securely.
- Consent was appropriately sought for each aspect of care and treatment.
- We saw leadership of each department was well organised and proactive. The senior staff had developed a local vision to complement the corporate vision and strategy.
- There were clear governance processes to monitor the service provided. Risks and audits were used to prompt remedial action and change practices to improve the service.

However, we also found the following issues the service provider needs to improve:

- The lack of permanent theatre staff impacted on procedures being undertaken. The fragility of theatre staffing had a direct impact on patients as procedures sometimes had to be cancelled.
- Cosmetic surgery practice was not monitored to ensure practice was in line with the Professional Standards for Cosmetic Practice – Cosmetics Surgical Practice Working Party, Royal College of Surgeons (RCS) Professional Standards.
- The matron had the responsibility to decide which incidents had an investigation. This response was not formalised to ensure a standardised approach was taken.
- There continued to be no assurance to confirm the photographs taken by consultants on their own cameras were held securely and images were deleted from the device or memory card immediately after they had been printed or sent to the patient.
- On call arrangements were not well organised to ensure patient safety and clear decision making processes
- The risk register recorded risks and action which were not all addressed in a timely manner.
- The staff survey results for 2018 showed that some areas of senior and corporate management scored poorly.

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

Amanda Stanford
Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good for safe, effective, and requires improvement for well-led. We did not inspect caring or responsive.
Outpatients and diagnostic imaging	Good 	The outpatients and diagnostic services worked with the surgical services to provide pre assessment and diagnostic review. Physiotherapy services also provided post-operative support. We rated this service as good for safe and well-led. We do not rate effective for outpatient services. We did not inspect caring or responsive.

Summary of findings

Contents

Good

Mount Stuart Hospital

Services we looked at:
Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Mount Stuart Hospital

Mount Stuart Hospital is an independent hospital and part of the Ramsay Hospital Group. The hospital is located in Torquay and opened in 1984. It treats NHS and privately funded adult patients; including self-funded and medically insured. The hospital has four outreach clinics which are for consultation only and are staffed by surgeons with practicing privileges.

The registered manager for Mount Stuart Hospital is the hospitals general manager, Jeanette Mercer, who has been in post since December 2009. The accountable officer for controlled drugs is the matron.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in governance. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Information about Mount Stuart Hospital

The hospital has two core services, outpatient services and surgery, and is registered to provide the following regulated activities:

Diagnostic and screening procedures

Family planning

Surgical procedures

Treatment of disease, disorder or injury

During the inspection, we visited the ward, theatres and outpatients and diagnostics areas. We also visited the cosmetic and therapy areas. We spoke with 10 staff including five registered nurses, one reception staff, two medical staff, and four senior managers. We spoke with three patients and one relative. During our inspection, we reviewed three sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital had been inspected previously in September 2016, which found that the hospital was not meeting all standards of quality and safety it was inspected against.

Activity (April 2017 to March 2018):

- In the reporting period April 2017 to March 2018, there were 5,163 inpatient and day-case episodes of care recorded at the hospital; of these, 75% were NHS-funded and 25% other funded. Of the 5,163 patients, 3,852 were NHS patients and 1,311 were private patients.
- Of the total surgical procedures, 26% were orthopaedic procedures, 17% were general surgery, 13% gynaecology and 13% cosmetic surgery.
- There were 5,834 total surgical procedures and 738 endoscopy procedures.
- There were 61 surgeons, 18 anaesthetists, and five radiologists working at the hospital under practising privileges. One regular resident medical officer (RMO) worked on a one to two week rota. There were also 65 registered nurses, 35 care assistants and five radiographers, as well as bank staff.

Track record on safety:

- One never event
- From July 2016 to June 2017 there were 210 incidents reported. Between January and May 2018 there were 94 incidents across surgery and outpatients. Of these

Summary of this inspection

incidents, 53 were clinical patient incidents, 21 were non-patient incidents, 12 related to business continuity, six related to safety and two were identified hazards.
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- There had been 18 complaints logged for the calendar year January to December 2017 and 14 for the rolling 12 month period from 1st July 2017 to 30th June 2018.

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff were suitably skilled to meet the needs of the patients. Mandatory training was provided for all staff and monitored to ensure all staff remained suitably skilled and updated.
- The safeguarding systems and processes ensured patient safety.
- Systems ensured cleanliness of the departments and promote infection control.
- The systems and processes in place to manage the environment and equipment kept patients safe.
- Investment in ward equipment was ongoing.
- Patients were suitably assessed and systems were in place to respond to risks to ensure patient safety.
- Patient records were well maintained and stored securely.
- Incidents were recorded and reviewed to provide learning and prevent reoccurrence.
- Management of medicines was safe.

However :

- The lack of permanent theatre staff impacted on procedures being undertaken. The fragility of theatre staffing had a direct impact on patients as procedures sometimes had to be cancelled.
- Staffing was planned and managed to ensure sufficient staff were available. Filling shifts at short notice was challenging for the ward and theatres and impacted on the work being undertaken.
- A consistent approach to incident investigation was not formalised to ensure a standardised approach was taken.

Are services effective?

Good

- Care and treatment was provided using best practice standards and evidence based guidance.
- The nutritional needs of patients were reviewed, assessed, monitored and met.
- Patients' pain was assessed and managed to ensure patients were comfortable.
- The outcomes of patients' care and treatment were collected and monitored to measure the quality of the service provided.
- Staff were appraised to ensure they had the skills, knowledge and experience to deliver effective care.

Summary of this inspection

- Staff worked well between departments and external services.
- Consent was appropriately sought for each aspect of care and treatment.

However, we also found the following issues that the service provider needs to improve:

- There continued to be no assurance to confirm the photographs taken by consultants on their own cameras were held securely and images were deleted from the device or memory card immediately after they had been printed or sent to the patient.
- Cosmetic surgery practice was not monitored to ensure practice was in line with the Professional Standards for Cosmetic Practice – Cosmetics Surgical Practice Working Party, Royal College of Surgeons (RCS) Professional Standards.

Are services caring?

This was a focused inspection which did not include this question.

Are services responsive?

This was a focused inspection which did not include this question.

Are services well-led?

Requires improvement

- We saw leadership of each department was well organised and proactive. Staff were highly positive about access to and visibility of their departmental managers.
- Corporate and local values were visible in the hospital and staff were in agreement with them. The senior staff had developed a local vision to complement the corporate vision and strategy.
- Staff we spoke with enjoyed working at the hospital and this was reflected by how long many of the staff had worked there.
- There were clear governance processes to monitor the service provided. Risks and audits were used to prompt corrective action and to change practices to improve the service.
- There was a systematic programme of clinical and internal audit to monitor quality.
- There was engagement of the public and patients in the outpatient and diagnostic service, and hospital-wide. Changes were seen as a result of patient engagement.

However, we also found the following issues that the service provider needs to improve:

- On-call arrangements were not well organised to ensure patient safety and clear decision making processes.
- The staff survey results for 2018 showed that some areas of senior and corporate management scored poorly.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	N/A	N/A	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	N/A	N/A	Good	Good
Overall	Good	Good	N/A	N/A	Requires improvement	Good

Good

Surgery

Safe	Good
Effective	Good
Well-led	Requires improvement

Are surgery services safe?

Good

We rated safe as Good

Mandatory training

- Staff undertook a system of annual mandatory training which was monitored to ensure completion. Mandatory training included basic and immediate life support, fire safety, moving and handling, infection prevention, safeguarding vulnerable adults and children, and mental capacity act and deprivation of liberties safeguards.
- Each area of the hospital kept a training plan and knew what training was required or planned for the year. Each area of the hospital kept a training plan and knew what training was required or planned for the year. The provider had a training benchmark of 85% However, mandatory training compliance was 82% overall.
- The service had increased the number of staff having advanced life support training to promote patient safety. Each area of the hospital had one member of staff on duty each day with advanced life support training. The remaining ward and theatre staff had completed immediate life support training. The Ramsay policy expects all staff administering sedation to update their immediate life support training annually to enable them to renew their practicing privileges agreement. The resident medical officer (RMO) had completed advanced life support training.

Safeguarding

- The safeguarding systems and processes were ensured patient safety. A safeguarding policy and flow charts were available within each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. One safeguarding alert had been raised since the last inspection in 2016.
- The matron was the safeguarding lead for the service. Matron had completed level three safeguarding training and was the point of reference and support for all other staff in the hospital. The safeguarding lead for Ramsay Health Care was contactable in working hours. Out of hours, staff could contact the local authority safeguarding lead for advice.
- Staff had undertaken safeguarding training. Of the staff employed, 99% of qualified nurses and allied health professionals had completed level two safeguarding training for adults as part of their induction and ongoing mandatory training. This was two part training with part A consisting of e-learning being completed every three years, and part B which was face to face annual training which included Deprivation of Liberty and Mental Capacity Act awareness. Staff confirmed training had been completed and they had sufficient knowledge and confidence to raise a concern if needed.
- Female Genital Mutilation (FGM) was included as part of the safeguarding policy. Staff confirmed training was provided as part of their safeguarding training.

Cleanliness, infection control and hygiene

- There were systems to prevent and protect patients from health associated infections. The provider had an infection prevention and control policy which was in date. Matron was the lead for infection prevention and control for the hospital. The infection control lead for Ramsay was available for advice.
- Patients were risk assessed for infection risk in outpatients as part of the key health questionnaire prior to their surgery.
- Between April 2016 and March 2017 there were no incidences of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium Difficile (C. Diff) and Escherichia coli (E-coli).
- There were systems to prevent and protect patients from health associated infections. Monitoring of surgical site infections took place and any infections identified

were reviewed. Between April 2017 and March 2018 there were 19 surgical site infections recorded. Data provided showed the surgical site infections did not show any specific trends.

- Good standards of hygiene were maintained. There were cleaning rotas maintained both on the ward and in theatres. Work was ongoing to remove carpets from patient rooms and replace with flooring which posed less of an infection risk. There were four rooms still carpeted with plans to remove in the near future. Enhanced schedules were in place during the interim.
- Cleaning of theatres was undertaken by porter staff and a rota was in place. We saw cleaning records were in place and completed by either the porters or theatre staff. These records covered before theatres were used and in between procedures. Audits of cleaning schedules took place monthly and showed a compliance of 99% in the last annual audit from December 2017.The information showed improvements in cleaning standards since the previous audit. There was also an infection prevention and control environmental audit for the ward area with an overall score for completion of 99%.
- Mandatory training for infection control stated that face to face training currently achieved 82% of all clinical staff.
- The sterile equipment for theatre was provided by the Mount Stuart sterile services department, which was on site. This was seen to be well managed, effective and audited to ensure a safe service was provided.
- Hand hygiene audits were completed for October 2017 and March 2018 and each scored 100%. Audits were completed across the outpatient department, ward and theatres and included a range of staff. In each audit 10 staff were observed.
- The hospital's most recent patient-led assessment of the care environment (PLACE) scores were 99%, in relation to cleanliness and infection control (2016/17). The anticipated score by the hospital for 2017/18 was 100%, although this had not been finalised.

Environment and equipment

- The systems and process to manage the environment and equipment kept patients safe. Audits of theatre equipment were undertaken with a record of items reported for repair and replacement. This enabled staff to have a clear picture of equipment available and the current state of repairs needed. When equipment was in need of replacement a two-tier system of ordering was in place dependent on the price of the order. Staff told us they could order equipment, however, some requests needed a business plan to identify the rationale for the request.
- Daily equipment safety checks were undertaken in theatres by the operating department practitioner (ODP). This included checks of oxygen cylinders. The anaesthetic machines also had a daily check recorded by the ODP. Staff confirmed the anaesthetists also undertook the checks but did not consistently record them and work was ongoing to ensure anaesthetists countersigned the ODP checks.
- There was a local risk register on the ward and in theatre for staff to record and review any locally identified equipment or environment risks and ensure actions were taken and monitored.
- The hospital's PLACE scores for condition, appearance and maintenance of the building had been 94% in 2016/17. The hospital believed from the review this would increase to 97% for 2017/18, but they were waiting for confirmation of this.
- Investment in ward equipment was ongoing. Sinks were available in the bathroom of each ward bedroom. Staff used these for hand washing and used paper towels to hand dry. This use of sinks for both patients and staff may pose a risk of cross-infection and staff were aware of how to manage those risks by ensuring that they keep hand drying towels separate or used the ward sink. A programme of carpet replacement was ongoing, with carpet in rooms being replaced with non-slip flooring.
- There was limited access to cardiac monitoring and automated blood pressure monitors for post-operative observation and not all rooms had access to piped oxygen, so cylinders needed to be used. These areas were not on the risk register and when requested staff told us that the access to monitoring equipment was due a review to ensure sufficient were available when needed.
- We saw resuscitation equipment available in each area of the hospital including the ward, theatres and recovery. The trolleys were checked daily and all portable equipment had been serviced within the last year. We saw a new emergency call bell system had been fitted in theatre to alert the whole hospital in case of an emergency.

- Previously we saw the X-ray gowns and lead aprons, which should all be hung separately, were hung one on top of the other (three to four gowns). We saw this had been addressed and they were now stored safely.
- A hoist was available for the safe moving and handling of patients. The hoist could safely hold patients with a body mass index (BMI) of up to 40. Should a patient require moving in excess of that BMI, then a risk assessment would be completed and a decision made about whether the hospital could cater safely for them.
- Fire training was provided and fire drill took place. Staff confirmed fire drills were now undertaken and while theatre did not evacuate, staff said they had received sufficient instruction to evacuate if needed.

Assessing and responding to patient risk

- Assessment of risks was undertaken prior to admission. A series of risk assessments were completed, including venous thromboembolism (VTE), nutrition, and risks of skin damage and falls. On admission the risk assessments were repeated and the patient confirmed they were asked if any changes had occurred since the key health questionnaire had been completed. All results from pre-operative investigations were reviewed to indicate suitability for surgery.
- A set of eligibility criteria was to ensure patients were suitable for treatment at this location. The hospital did not provide care and treatment for patients who had complex needs or needed care which the hospital's staff could not safely provide. Post-surgery, the provider did not have facilities or staff with suitable training to care for patients with higher dependency needs. Should an increased level of dependency unexpectedly occur the patient would be transferred to the local acute trust by emergency ambulance. A service level agreement had been agreed with the local trust for the transfer of patients if needed.
- The service for each patient was consultant-led for both day surgery and inpatient admission. Pre and post-surgery, the consultant saw the patient and remained on-call out of hours to respond should there be need to contact them. Most consultants were local and it was their responsibility to provide cover should they be unavailable. In the interim, the resident medical officer (RMO) was available to provide medical support. An escalation procedure was used,. Should a patient deteriorate, nursing staff would escalate to the RMO who would in turn escalate to the consultant.
- Theatre staff followed the five steps to safer surgery. This involved following the World Health Organisation (WHO) checklist before, during and after each surgical procedure. We observed this procedure taking place.
- The WHO checklists were audited to provide assurance they were correctly and fully completed. Full audits of all areas were undertaken every six months, with monthly observation audits also undertaken. Results showed consistent compliance between 90% and 100%, and any shortfalls were reviewed and actions taken to prevent reoccurrence. Audit results and any issues were reviewed at the quality and governance meeting and learning was shared across the hospital.
- Patients were monitored for deterioration in condition. The provider used early warning scores (EWS) to monitor for changes in condition including triggers of sepsis. Staff had received training on using the EWS and to recognise sepsis. A sepsis action pathway was available in each patient's notes on the back of the EWS record. We reviewed three sets of patient notes and saw observations had been completed in each case. Calculation of scores had been completed and appropriate action taken in response.
- Theatre observation audits included safer surgery checks, anaesthetic checks, intra operative care, post anaesthetic care and accountable items, swabs, instruments and needles. Five sets of records were reviewed at each six monthly audit; those audits scored 100% in July 2017 and 99% in May 2018. In between those audits, smaller observational audits took place, which included areas such as site marking, swab counts and prosthetic verification.
- There was also a theatre operational audit which included the World Health Organisation areas of practice. This audit was undertaken annually and showed an improvement from July 2017 (91%) to May 2018 (99%).
- The theatres had implemented a white board system to cover all areas of the WHO checklist during the patient's theatre visit. The information was then transferred to a paper copy which was retained in the patient's notes and audited as part of the patient's medical records audit.
- Resuscitation processes were clear for staff and training had been provided. A corporate resuscitation policy was available and resuscitation scenarios had been undertaken. Staff told us this was a valuable exercise with learning identified. A resuscitation team was

allocated daily. Each member of the resuscitation team carried a bleep to alert them if needed and these were tested weekly. Previous inspections had highlighted the lack of an emergency call system in theatre recovery. This had been addressed with a call system that sounded throughout the hospital if needed.

- A system was implemented to ensure that if staff were called in, safe staffing was managed for the following day. Should a patient require an unplanned and unexpected return to theatre and it was out of normal working hours, there was an on-call theatre team rota. The ward staff would contact the team who consisted of the consultant, anaesthetists and three staff members.
- Auditing of VTE showed that in the time period April 2016 to March 2017 Mount Stuart Hospital scored slightly above the England average. A full VTE audit took place every six months, with internal audits undertaken monthly. Any actions were addressed and followed up the next month to prevent reoccurrence. All VTE issues and audit results were reviewed at the quality and governance meeting and learning shared across the hospital.
- We looked at three sets of records and saw a risk assessment had been completed for each patient and a plan for VTE prevention. We did not see any post-operative review of VTE.
- Pressure area care was assessed and monitored to prevent skin damage. Pressure area care assessments were completed pre and post operatively. Pressure relieving equipment was available and early mobilisation was encouraged for patients. Any assistance needed to change position in bed was provided.
- Cosmetic services were provided and specific risks were considered. Appropriate consideration was given around body image and patient expectations. While psychological reviews were not routinely undertaken, systems were available for the surgeon to raise the issue of body image and record any risk. A further question was asked if the patient would like to be referred to a clinical psychologist prior to surgery to help with the decision making process. A psychologist had been sourced to provide any addition support on request.
- Systems to support patients after discharge were available. A telephone contact line was available for all patients discharged. This enabled them to ring the hospital, both day and night, with any concerns.

Nursing and support staffing

- Staffing was planned and managed to ensure sufficient staff were available. However, there were not enough whole time equivalent staff employed by Ramsay Health Care to staff the three theatres. There was a shortage of permanent theatre staff. Staff shortages were being managed through recruitment and in the interim shortages were being filled by bank and agency staff. There were currently two theatre trained staff vacancies with a further three bank staff vacancies, which equated to five whole time staff short of the full staffing compliment. We saw that between June 2017 and May 2018, 5% of all shifts in theatre were covered by agency staff which was a significant improvement since the last inspection in 2016 when 44% shifts were covered by agency staff. Actions were in place to mitigate any staff shortage impact, including not running three theatres five days a week, weekly reviews via theatre utilisation, and risk assessment
- Filling shifts at short notice was challenging for the ward and theatres and impacted on the work being undertaken. The provider told us the theatre department used AfPP (Association for Perioperative Practice) guidelines for determining staffing levels, whilst also taking into account the surgical speciality. The skills required were matched with the staff skills available. The theatre manager had to frequently work clinically to cover staff shortfalls, which reduced their administrative time.
- The theatre rota was done two weeks in advance and agency and bank staff were requested to fill the vacancies. A system had been implemented to prevent late additions to the theatre list to ensure staffing to meet the planned list was not affected by any changes. The list could be altered by the registered manager if they considered it appropriate. We were aware of a procedure on the cosmetic surgical list which was planned for 5pm, the surgery was extended due to its complexity,this meant an extra pressure for staff and a longer working day.
- The lack of permanent theatre staff impacted on procedures being undertaken. We were made aware of the fragility of theatre staffing and the direct impact on patients. If one staff member was unexpectedly not available because of sickness and agency staff could not be agreed and found, then the theatre list may be cancelled. This remained an issue for the service since

the last inspection. A risk assessment had been put in place setting out mitigating actions if resources could not be provided. Over the period June 2017 to May 2018 this had happened on seven occasions with a total of 31 cancelled operations. In the same time,8.3% of theatre cancellations were caused by staffing issues in theatre. On the day of inspection this had happened and the staff member for day theatre had to be reallocated to main theatre, which meant the day theatre list was cancelled

- On the ward there were three full time posts vacant and a health care assistant vacancy. Ward staffing levels were calculated using Ramsay's staffing guidance and reflected the number of patients and their dependency. Staff were rostered via Ramsay's electronic health roster system. Rosters were reviewed against patient activity and staff availability on a daily and weekly basis. Ward staffing was discussed and evaluated at each staff handover meeting to ensure staffing was safe. The ratio basis used was 1:5 registered nurses to patients in the day and 1:7 at night. We saw that between June 2017 and May 2018, 3.4% of all ward shifts had been covered by agency staff. Each day a senior nurse was on duty at all times on the ward.
- Safe staffing on the ward was impacted by changes in the theatre list. The newly implemented 10-day restriction to changing the theatre list improved theatre and ward working. However, if theatre accepted an alteration to the theatre list, this was not consistently checked with the ward and created an increased pressure to find the right number of skilled staff to ensure patient safety. No incidents had occurred but there was potential to create a staffing risk.
- In the physiotherapy department, staff told us they had been working short of their full staff complement and had been required to work late on occasions. The hospital confirmed that recent difficulties with staffing had occurred due to some long-term sick leave.Recruitment to the physiotherapy team was ongoing to meet the patients' needs.
- Staff turnover was lower than the company average. In 2017 the staff turnover was 12%, measured against the company average of 16%.
- Staff sickness was just lower than the company average. Staff sickness was 3.37%, which rated the hospital 14 out of 35 in the company overall.
- Systems to review staffing were activated if an unexpected return to theatre took place overnight. The theatre manager confirmed that if an unexpected return to theatre took place which required staff to be called in, the following day's list would be adjusted to the staffing available and ensure patient safety.

Medical staffing

- Surgery was consultant-delivered with appropriate out of hours care provided. Consultants were responsible for their own patients 24 hours a day, seven days a week. It was the responsibility of each consultant to cover their own absences and ensure the person they appointed to cover for them had the appropriate skills and practicing privileges agreement.
- There were over 95 consultants working under practicing privileges arrangements covering a variety of surgical specialities, including orthopaedic and cosmetic surgery. A further 10 were on another hospital's database pending transfer. The provider checked as part of the practicing privileges arrangements that the surgery performed by a consultant was what they undertook in their usual place of work. They also checked how many procedures had been completed. This was to ensure sufficient competence to keep patients safe.
- Each consultant and anaesthetist saw their own patients pre and post operatively and were available on call until the patient left the hospital. This included overnight or for several days, and included out of hours and weekends.
- The provider employed one anaesthetist directly who did not also work for the NHS. This meant their appraisal was undertaken by the Ramsay medical director. Other anaesthetists were employed under practicing privileges. The anaesthetist involved with the patient's surgery was also on-call for the duration of their stay. Should they become unavailable it was their responsibility to provide anaesthetic cover for any unplanned returns to theatre.
- The resident medical officer (RMO) was provided by an outsourced agency and was available on site 24 hours a day for the period they were on rotation, which was usually one or two weeks. The RMO was managed by the matron and was supported by the agency that employed them.

Records

- Patient records were well maintained and stored securely. Each patient had a care record which included

all pre-admission assessment, investigations and results, and risk assessments. The pre-admission assessment was used to ensure patients met the safe criteria to have treatment at the hospital. Once admitted, the records included a pre-operative checklist, anaesthetic room care, care during the procedure, and recovery care. Post procedure forms were completed each day and recorded risk assessments, interventions and outcomes.

- Records were well completed and provided an audit trail of care provided. We reviewed three sets of records and found them to be completed and readable. The records maintained of the patient's time in theatre were fully completed and included the World Health Organisation (WHO) safety checklist undertaken prior to surgery, and identification of any prosthesis used. We also saw pre-printed discharge letters to GPs were ready for patient discharge.
- Patient medical record audits had taken place in July 2017 and May 2018. Both showed 97% compliance.
- A policy was used for the security of medical records outside Ramsay Healthcare facility. The policy advised staff of their responsibilities when removing records outside of Mount Stuart Hospital. The removal of notes by surgeons was not normal practice and was discouraged.

Medicines

- Systems were in place to manage medicines safely. A pharmacist had been in post since 2016 and provided clinical support to theatres and the ward on two days a week. Medicines, including emergency medicines, were available to patients and were prescribed on prescription and administration charts. Allergies were recorded in the patient care record and on patients' individual drug charts.
- Medicines were stored correctly. We saw the temperature of areas used to store medicines was recorded, and was within safe parameters. The storage of fluids had been reorganised in theatres to ensure they were stored correctly and appropriately monitored for temperature and expiry.
- We noted an incident had occurred where a patient was given out of date medicine. This was followed-up by ward and pharmacy staff and it was found the patient had not had an adverse reaction. A plan of action had been implemeneted to prevent reoccurrence.
- The nurses dispensed medicines in the treatment room during the night shift, for people to take home the next day. These medicines were left locked away for other nurses to check before being dispensed.
- Since the pharmacist had been in post, prescribing, controlled drugs, and medicines management audits had been completed. There was a prescribing audit in November 2017 which demonstrated 97% compliance. The April 2018 audit of medicines management showed 88% compliance. The drop in score for the April medicines management audit was attributed to non-compliance with temperature monitoring, which had since been addressed. A newsletter went out to staff in June 2018 to highlight areas for improvement. The pharmacist had plans to work with the matron to develop an action plan regarding the areas where improvements still needed to be made, including adherence to hospital policy around the use of unlicensed medicines.
- The hospital matron was the accountable officer for controlled drugs and the general manager had overall responsibility for ensuring appropriate destruction of controlled drugs. Staff explained a safe disposal process.
- The hospital provided a blood transfusion policy and training for staff for the issuing of blood. The hospital had a lead nurse for blood transfusion training. Blood units were barcoded, but no scanning facilities were available so all checks were done manually by staff before blood was administered. The temperature of storage was recorded daily to ensure safe storage was maintained.

Incidents

- Incidents were recorded and reviewed to provide learning and prevent reoccurrence. From January to May 2018 there were 94 incidents across surgery and outpatients. Of these incidents, 53 were clinical patient incidents, 21 were non-patient incidents, 12 related to business continuity, six related to safety and two were identified hazards. The provider's Quality Accounts for 2017 to 2018 showed an increase in incidents which they noted to be as a result of better reporting. The management of the hospital advised that the increase in incidents was reflective of the increase in activity and reporting. However, minutes from a department meeting noted the increase was caused by an increased workload and staff sickness levels.

Good

Surgery

- An overview of incidents was discussed at clinical meetings. Any trends which were appearing in incidents at a local (hospital) and Ramsay wide (corporate) level were reviewed at these meetings.
- An incident policy highlighted to staff the approach to incident reporting and the responsibilities of staff in incident investigation. Incidents were coded using the Ramsay corporate coding where one was the most severe and four the least severe. There had been no level one incidents and 16 level 2 incidents between July 2017 and June 2018. The policy noted that for severity one and two a root cause analysis would be prompted by the electronic recording system. We reviewed five incidents in this category, and we found two did not have a root cause analysis completed. This response was not formalised to ensure a standardised approach was taken.
- Incident investigations were delegated by the matron to the appropriate head of department. The head of department was responsible for completing the investigation and putting together a response. The matron reviewed all investigations. Staff involved in incidents and investigations confirmed learning was identified and undertaken to minimise incidents happening again. Incidents reviewed showed appropriate action was taken. We reviewed eight level two incidents. We saw the issues were reviewed and actions taken. Actions were reviewed as part of the ongoing governance process to ensure that actions prevented reoccurrence.
- In the last 12 months there had been one never event. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The never event had been investigated and learning identified and shared with other hospitals in the company group.
- There had been no expected or unexpected inpatient deaths at Mount Stuart since our last inspection in September 2016. If deaths did occur these would be reviewed and discussed at the clinical governance and Medical Advisory Committee (MAC) meetings and lessons learned would be highlighted and shared.
- Staff had a clear understanding of the 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.
- The Ramsay corporate policy for duty of candour was included in the 'Being Open Policy.' This provided guidance on being open and referenced the NHS standard contract requirement for duty of candour, stating that 'notification to be at most within ten working days of the incident being reported.' We reviewed three records, which included an explanation and apology for shortfalls in service. A duty of candour log had been implemented to ensure it was considered and completed. We saw the provider followed their own policy and recorded discussions and the apology when required.

Safety Thermometer (or equivalent)

- Monitoring of patients' safety was undertaken and results reviewed to develop the service. At the time of our inspection, 70% of patients at Mount Stuart hospital were funded by the NHS. The national NHS patient safety thermometer was used to look at safety issues related to pressure ulcers, falls, venous thromboembolism (VTE), and catheter associated urinary tract infections. For all NHS patients, data was submitted centrally for one day each month. Data produced showed 100% compliance with all aspects. The results of the safety thermometer were reviewed at the clinical governance meetings and the MAC meetings.
- For patients who were privately funded and so not monitored under the NHS safety thermometer, these safety issues were monitored through the hospital's audit process.

Are surgery services effective?

Good

We rated effective as good**.**

Evidence-based care and treatment

- Care and treatment was provided using best practice standards and evidence-based guidance. Local clinical audits were completed in line with Ramsay's audit programme and results were shared at the local Clinical Governance Committee and scrutinised by the

Corporate Clinical Team. Results also informed the integrated monthly governance reporting to Ramsay Corporate and the Clinical Commissioning Group. Audits included length of stay, complications, readmission, and return to theatre, cancellations and transfers.

- Patient-related data for patients undergoing hip and knee surgery data was submitted to the National Joint Registry (NJR). Data was submitted to enable monitoring by the NHS of the performance of joint replacements. Data was also submitted to the National Ligament Registry (NLR) and Patient Reported Outcome Measures (PROMS).
- Ramsay corporate policies, documents and clinical audits were based on guidance as appropriate. All care pathways were evidence-based and related to the most recent national guidance. These included National Institute for Health and Care Excellence (NICE) Guidance (2010) 'VTE – reducing the risk' and NICE (2007) 'Acutely ill patients in hospital'.
- Staff training for National Safety Standards for Invasive Procedures (NatSSIPs) had been provided to support safety standards and for future safety developments.
- Cosmetic surgery practice was not monitored to ensure practice was in line with the Professional Standards for Cosmetic Practice – Cosmetics Surgical Practice Working Party, Royal College of Surgeons (RCS) Professional Standards.
- The hospital had Joint Advisory Group (JAG) accreditation for its endoscopy service. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its competence to deliver against the measures in the endoscopy standards.
- The hospital participated in the Patient Led Assessment of the Care Environment (PLACE) audit annually. The most recent inspection concluded that in most areas the scores had improved.

Nutrition and hydration

- The nutritional needs of patients were reviewed, assessed, monitored and met. At pre-assessment, any special diets were identified. The malnutrition universal screening tool (MUST) was used to assess each patient's level of risk. Patients' records identified their specific needs and patients told us their nutritional needs had been met.
- Instructions about pre-operative starvation times (nil by mouth) was given during the patient's pre-admission visit. We observed staff checked as part of pre-procedure checks in theatre when the patient last ate or drank and this was recorded in the patient's care record.
- We were told intravenous fluids were prescribed post-surgery; however, none were prescribed at the time of inspection and so no records were available for our review.
- There was access to a dietitian. Should advice be needed then staff confirmed they would contact the local trust for advice.
- The hospital's PLACE scores were 90% for food and hydration.

Pain relief

- Patients' pain was assessed and managed to ensure patients were comfortable. We saw pain relief was discussed pre-operatively, in recovery and on the ward. Post-operatively, the level of the patient's pain was monitored using a pain score card (0-10 pain score, with 10 being the highest level of pain) and the response and actions taken were recorded in their records.
- Three patients we spoke with confirmed they were comfortable and pain relief was well-managed.
- Controlled drugs were stored, administered, recorded and disposed of correctly. Nurses administered medicines in a safe manner and signed the administration chart as appropriate, or recorded the reason why people had declined to take medicines.

Patient outcomes

- The outcomes of patients' care and treatment were collected and monitored to measure the quality of the service provided. The hospital uploaded data to the National Joint and Ligament Registries and Patient Related Outcome Measures. The hospital had submitted data from all their hip and knee patients between April 2017 and March 2018. No actions had been required to be reviewed by the clinical governance committee to improve the quality of healthcare.
- Between April 2017 and March 2018, 100% of cases were submitted to the National Bariatric Surgery Registry.
- For Patient Reported Outcome Measures (PROMS), Mount Stuart Hospital was around the England average score for groin hernias between April 2016 and March 2017.
- There were no external audit results available for cosmetic surgery.

- A proportion of Mount Stuart Hospital income was conditional on achieving quality improvement and innovation goals agreed with their commissioners. One of the goals was to ensure patients were assessed in compliance with the commissioner's policy and clinical referral guidelines for a selection of treatments. These had been successful and carried on to the next year.
- The provider monitored outcomes that affected patients at Mount Stuart Hospital. These included transfers to the local hospital trust when patients' care requirements exceeded the care able to be provided at Mount Stuart. It also included when patients had to be readmitted or unexpectedly returned to theatre. From January to June 2018, 12 patients were transferred to the local trust, five patients had to unexpectedly return to theatre and four patients were readmitted to Mount Stuart. On each of these occasions, the incident was recorded, including reasons and outcomes. These incidents were reviewed at the clinical governance meetings and transferred to the risk register if needed. The incidents did not demonstrate any consistent themes.

Competent staff

- Staff were appraised to ensure they had the skills, knowledge and experience to deliver effective care. Nursing staff and allied health staff appraisals were ongoing and mostly completed. From April 2017 to March 2018, 90% of staff appraisals had been completed with the remaining 10% delayed by long-term sickness and maternity leave.
- Practising privileges arrangements for medical staff was monitored by the hospital's director and human resources manager. Medical staff appraisals and indemnity insurance were all up to date. Any complaints or incidents relating to the consultant would be reviewed as part of the appraisal process.
- Where a consultant applied for practising privileges they were required to evidence they were undertaking the procedure in another hospital. Details of the proposal were then submitted to the Medical Advisory Committee (MAC) for approval. The MAC chairman would review the submission and a discussion would take place to decide if the new practice could commence.
- Staff told us induction training and ongoing training was provided. Theatre staff confirmed human factors training had been implemented to their training schedule to support safe practice. Human factor training is about understanding behaviour and performance to improve safety.
- Agency and bank staff were suitably orientated to the service to ensure safe patient care. An orientation checklist was available for agency staff to complete when they started work at Mount Stuart Hospital.
- Surgical first assistants were enabled to attend the operating theatres with the surgeon. However, this was not possible until all the checks had been completed and the human resources office had completed the appropriate security checks. Extended access to first assistant training had been provided to existing theatre staff and five staff had completed this training.

Multidisciplinary working

- There was communication between departments with good handovers of patient information. Communication was good between nursing and allied health professionals to support patients pre and post-surgery. The daily meeting enabled a discussion of any multidisciplinary work needed and should therapists not be able to attend, a handover of information was provided.
- Medical handovers took place as needed. The consultant handed over any information they felt relevant to the Resident Medical Officer (RMO) before leaving the hospital. Staff could contact the consultant when they felt there was a need to.
- Development in the service had promoted further multidisciplinary working. The provider had developed the service to include some transgender and bariatric work. This required developed multidisciplinary working with the specialised referral agencies.
- Working with stakeholder agencies took place. The matron attended meetings at the local hospital trust and with commissioners as part of joint working and commissioning arrangements.
- Discharge planning was considered at pre-admission and at each stage along the patient's pathway. Nursing staff liaised with families and carers on admission to check there would be suitable care provision available before treatment started. The patient's GP and the consultant were able to speak by telephone to ensure a continuity and accuracy of information provided.
- There was limited formalised pathway of information between the Mount Stuart Hospital and the local

hospital trusts. There were limited systems to ensure information of relevance, such as admissions to the trust following treatment at Mount Stuart Hospital, was communicated. This meant learning could not consistently be taken from potential incidents.

Seven-day services

- The hospital provided elective surgery Monday to Friday from 8am to 8pm. Occasional Saturday theatre lists were planned but this was not normal practice. If the ward was empty at weekends or bank holidays the service would close for that time.
- Nursing staff and the RMO were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of senior management was available to support staff as part of an on-call rota.
- The surgical services were able to access support from other health care professionals out of hours. A radiographer was available and was contactable out of hours. Radiography services were not available at weekends but some scan facilities worked at the weekend.
- Physiotherapists worked on the ward from 8.30am until whenever they were needed. One physiotherapist was on the ward each day. Out of hours physiotherapy could be called for advice by the ward staff.
- Pharmacy service was available two and three days per week with pharmacist working five days every two weeks. Outside of these working days the Ramsay Healthcare group pharmacist or pharmacist from the sister hospital could be contacted for advice. Should a prescription be required outside of those days a porter was sent to the local pharmacy to pick up the medicine.
- There was an out of hours on-call theatre rota available, including the patient's consultant and anaesthetist, should a patient need to return to theatre.

Health promotion

- Health promotion was encouraged to support NHS initiatives for weight loss and stopping smoking. Pre-assessment 'In Shape for Surgery' incorporated carbon dioxide testing/smoking cessation. A drive was also promoted for patients losing weight so they could go ahead with surgery.
- Staff-related health promotion included: flu vaccinations, step challenge, and mindfulness sessions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was appropriately sought for each aspect of care and treatment. A consent policy detailed how consent was to be obtained and the consideration of capacity to make informed consent.
- The service rarely accepted referrals for patients who lacked the capacity to consent. We saw three sets of records and all showed the patients had capacity to consent and the forms were fully completed and signed by the consultant and the patient. The consent form also included a facility for a translator to sign to say what input they had provided.
- Consent was completed by the consultant or nurse at the pre-admission visit (consent form one) and again during the procedure preparation (consent stage two). We spoke with a consultant surgeon who confirmed this was the correct procedure.
- For cosmetic procedures, consent should be a two stage process including a two-week 'cooling off' period to enable the patient to reflect on their decision. Staff explained that often the period between pre-assessment and admission was considered to be the cooling off period and that should the patient not wish to continue they would not attend for admission.
- The hospital's internal audit process showed 10 patient records had been audited in January 2018 and June 2018, and specifically audited the consent process. The overall score for consent completion and recording in June 2018 was 99%.
- Mandatory training was provided for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards as part of the part B safeguarding training. The provider had a mental capacity policy, which referenced the Mental Capacity Act and provided staff with a flowchart to follow should a patient be identified as lacking capacity. For patients with a fluctuating capacity , extra staff were used to support those patients on a one to one basis.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership

Good

Surgery

- The hospital had a senior management team, with each department being led by a Head of Department. The hospital senior management team consisted of the general manager, matron, operations manager, finance manager & business administration manager. The general manager undertook the general running of the hospital and was supported by a regional director who visited the hospital monthly and also undertook provider inspection-type visits.
- Medical leadership at local level for surgery was the MAC chair. Matron had overall responsibility for all clinical services, including outpatients (including cosmetics), pharmacy, radiology, theatres, physiotherapy, decontamination, ambulatory care and ward. Each department had its own lead. The Resident Medical Officer (RMO) was responsible to the matron.
- We saw leadership of the ward by the ward manager was well-organised and proactive. Leadership of theatres demonstrated an updated understanding of governance and the use of audits to develop service and safe practice. The therapist team was led by the outpatient manager. The clinical sterile services department was managed by the operations manager who was also the decontamination manager.
- The heads of department met once a month. The meetings covered a range of topics, including hospital activity, business development, new legislation, policies, HR, training & development, IT, complaints, claims, compliments, incidents, information security, departmental reviews, feedback from clinical heads & leads and new business. There was also a separate monthly meeting for clinical heads and leads covering – policies, alerts, incidents, CQC/Provider visits, audits, clinical risk register, clinical strategy & key departmental updates. The matron was considered to be approachable, but not consistently visible as they did not work clinically at any time.
- On-call manager arrangements were not well organised to ensure patient safety and clear decision making processes. The manager on-call rota was supported by a Ramsay policy. However, no formalised handover took place to the duty manager to highlight any areas of concern or potential matters arising. This meant that if decisions about the next day, including potential cancellations of theatre lists were needed, no timescale or potential alternative arrangements were considered.
- The staff survey results for 2018 showed that some areas of senior and corporate management scored poorly. A question about the senior management team taking the views and opinions of staff seriously scored 29%. This was a deterioration in score as the previous year had scored 49%. Staff were asked if they felt able to communicate upwards through the company and 56% of staff felt they could. Only 49% of staff felt there was a positive and inclusive atmosphere within Ramsay Healthcare. The lower scores had been identified for department leads for discussion and actions to take the issues forward. This work was currently ongoing.

Vision and strategy

- The senior staff had developed a local vision to complement the corporate vision and strategy. The corporate values for the hospital were called 'The Ramsay way'. Staff had not been included in developing that vision and strategy for the service. The matron had been instrumental in developing the local hospital based set of vision and values. The local values were used in the staff induction to form part of staff training. Heads of department had been included in developing these values and we saw them displayed in each area.
- Staff told us the newly implemented local visions were used to guide their one to one discussions, which helped to embed the values into each department.

Culture

- Staff survey results provided a varied response. Scores were high 94% to 99% for staff understanding their role, teamwork and providing patient care. However, the hospital scored 16% for a question about the corporate team listening and acting on staff views and concerns. This was a deterioration on the previous years score of 34%. Only 28% of staff felt supported during periods of change and 29% felt the corporate team communicated what staff needed to know.
- We spoke with some staff who said the hospital culture encouraged candour, openness and honesty. We recognised many positive changes from our previous inspection in 2016, however some staff told us they were often under pressure and the response of some senior management was not consistently supportive.

Governance

- There were clear governance processes to monitor the service provided. It is recognised that significant improvements in auditing, monitoring and governance have been made.

- There were a series of meetings which incorporated the governance strategy. The hospital's senior management team met most Tuesdays. These meetings were a forum to discuss a wide range of business items, including current and future activity, new policies and legislation, complaints, information security, significant events and incidents and the risk register. On the weeks the senior team did not meet, there was a head of department's meeting.
- The Medical Advisory Committee (MAC) met quarterly and had a representative from each surgical speciality and was an integral part of the governance structure. Facility rules werein place from Ramsay Health Care, which included the composition of the MAC, terms of appointment and role specification. It included the MAC's role to participate in, and implement, the plan of quality programmes. The MAC was led by a chairman. A summary of all MAC discussions were provided to each consultant to ensure they were updated.
- The Clinical Governance Committee met quarterly and included the MAC lead and the matron. We looked at minutes for the meetings in December 2017 and April 2018 and saw it was chaired by the MAC lead and had seven staff attending. Agenda items included review of incidents, complaints, update reports from clinical committees, and policy updates. There was a summary of actions with a due date, with an update at the start of the next meeting's minutes.
- A clinical audit strategy had been implemented for 2017/18 in order to achieve a clinical audit programme in all departments. The audits were planned to drive and measure the quality of clinical care. The audit programme was undertaken twice a year and was supported by smaller local audits. The data was then benchmarked across the other Ramsay services. Mount Stuart hospital had a score of 92% for audit completion.
- Audits were completed in line with the company's own policy and were supported by smaller audits locally to provide ongoing monitoring. An audit register had been implemented to ensure all audits were completed and actions taken forward. Audits were benchmarked against national audits when possible and against hospitals in the provider group. Audit plan review meetings had been implemented, which identified any outstanding audits and reviewed any management actions. The annual audit plan was reviewed by the clinical governance meetings and the provider head office and completion. An example of audit improvements was the introduction of e-learning training for all staff for venous thromboembolism (VTE) corporate assessment. This commenced at pre-assessment and followed the patient on their journey through the hospital.
- Staff meetings had been improved and now took place regularly. The theatre and ward meetings had changed format to be a huddle twice a week with information and learning exchanged. There were monthly department meetings which had a standing agenda and other business, and recorded discussions to update the staff not able to attend.
- Each day a hospital meeting took place at 9am and a representative from all departments attended. The day's activities were discussed and this information taken back to each area and disseminated to staff. Handover of information took place at each shift change to ensure all staff were aware of the day's activities and plans.

Managing risks, issues and performance

- Risks were used to prompt actions. There was a corporate risk register and a newly developed local risk register for Mount Stuart hospital, which enabled each department to input, review, action and monitor risks at the hospital. The local risk register was overseen by the matron and registered manager and was currently being reviewed to include corporate risks. Some areas of risk recorded were not addressed in a timely manner, however, further review was planned.

Managing information

- The hospital's website provided some information about treatment and payment options.
- Patients had two sets of records whilst in hospital. Patients, and staff who needed it, had full access to those records.
- We saw that when patients were discharged, staff provided literature on the specific aftercare needed for their procedure and ensured patients understood the content.
- The provider used data to monitor the service and drive improvement. We saw audits were used to gather data and then the data used to make changes to the service or monitor the service. For example, we saw hygiene audits being used to demonstrate effective systems and then the information monitored at governance meetings. Any changes were fed back to staff.

Good

Surgery

Engagement

- Patient engagement included patient satisfaction, friends and family test, direct patient feedback and insurance provider feedback. 'Hot Alerts' were produced covering both positive and negative feedback from patients. These were sent to the general manager and matron each Friday for cascading to all staff.
- The hospital used the NHS Friends and Family test to monitor the care and experience of NHS patients. Responses received for February and March 2018 varied between 63% and 100%. The England average was 96%. Both NHS and private patient were included in the NHS survey. The gathering of experience and engagement data also took place through a corporate-led patient satisfaction survey. This indicated patients' overall experience of care at this hospital was scored at 96.4% in 2017, an increase from 2016.
- Staff were engaged through a staff survey with results included in areas of well led in this report.

Learning, continuous improvement and innovation

- There had been a recent development to undertake transgender surgical work. Appropriate systems had been implemented to ensure referral pathways were appropriate.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Mandatory training

- Mandatory training was provided for all staff and monitored to ensure all staff remained suitably skilled and updated. Staff undertook a system of annual mandatory training which was monitored to ensure completion. Mandatory training included basic and immediate life support, fire safety, moving and handling, infection prevention, safeguarding vulnerable adults and children, and mental capacity act and deprivation of liberties safeguards.
- Each area of the hospital kept a training plan and knew what training was required or planned for the year. The provider had a training benchmark of 85% However, mandatory training compliance was 82% overall.
- Training sessions had been tailored to fit the staff requirements. Smaller 'bite-sized' teaching sessions had been implemented between May and September 2018. Topics included risk management and safeguarding. Updates of clinical and non-clinical training were also available, but were felt by staff to be more nurse focussed.

Safeguarding

- Suitable safeguarding systems promoted the safety of vulnerable people. The hospital matron was the safeguarding lead and attended a local safeguarding forum, forming safeguarding links within the local area to ensure safe and updated processes were followed.
- The corporate safeguarding adults at risk of abuse or neglect policy were available for staff. This included information on female genital mutilation.
- The outpatient, radiology and cosmetic departments displayed the safeguarding contact numbers so these were easily available for staff. Staff were aware of their responsibilities to report safeguarding and the processes they should follow.
- The majority of staff had undertaken safeguarding training. We were told staff completed adult and children safeguarding training. Children were not treated in the outpatient department but sometimes attended with their parents and so the training was considered relevant. All radiology staff had completed their safeguarding children e-learning modules & face to face training to Level 2. Of all the staff employed, 99% of qualified nurses and allied health professionals had completed level two safeguarding training for adults as part of their induction and ongoing mandatory training.

Cleanliness, infection control and hygiene

- Systems followed ensured cleanliness of the departments and promote infection control. The departments appeared visibly clean. The housekeeping staff were responsible for cleaning departments and nursing staff were responsible for ensuring the cleanliness of consulting rooms and equipment. We saw evidence of completed department cleaning schedules and checklists.
- Between April 2015 and March 2016 there were no incidences of hospital-acquired infections, including Methicillin-resistant Staphylococcus Aureus (MRSA), Methicillin-ensitive Staphylococcus Aureus (MSSA), Clostridium Difficile (C. Diff) and Escherichia coli (E-coli). Patients were screened for MRSA at pre-assessment in line with corporate policy.
- Reception staff encouraged patients to use the alcohol hand gel available on reception. Hand gel was available on the reception desk. We observed good infection control practice amongst different staff groups, including the use of hand gel, compliance with the five moments of handwashing between patients and use of personal protective equipment, which was readily available.

Good

Outpatients and diagnostic imaging

- Clinical hand wash basins were available in all consulting rooms. Clinical hand wash basins were also available in the physiotherapy department. Paper towels were appropriately located next to clinical hand wash basins and hand washing good practice posters were displayed alongside the majority of these.
- The treatment rooms we inspected had vinyl flooring, which meant it was easier to keep clean. The flooring had been replaced as part of an ongoing refurbishment programme to remove carpets and so reduce the risk of cross-infection.
- The department used a three-part decontamination system to decontaminate the equipment between patients. It was confirmed staff wore apron and gloves as personal protective equipment while using the decontamination system, goggles were also available. Endoscopes were taken to the sluice to be decontaminated and training had been provided to staff. The ultrasound department had a cleaning procedure for intra-cavity probes. All probes were cleaned with the appropriate decontamination system wipes.
- There were 12 scopes in use and staff had completed the appropriate training for their cleaning. All equipment sterilisation staff had received leak tester training, except for a new member of staff who was scheduled to complete training before undertaking the role. There were 11 staff in the outpatients department trained on cleaning using stage three Tristal System and Leak Testing.
- The hospital's committee structure included the infection control committee. The matron was the infection prevention control lead. The committee met quarterly and reviewed audit and performance, new policy implementation, decontamination, review of risk registers and any infection control incidents. This report then fed into the clinical governance committee to inform the management of any current or ongoing issues.
- Infection control audits, including hand hygiene audits and environmental audits, were completed within the outpatient departments. The operational audit for outpatients scored 92%. The operations manager was aware of the risk and a risk assessment had been completed. An action plan was implemented to manage the risk safely. Hand hygiene audits in February 2018 in the outpatient department scored 99% and in the physiotherapy department 99%. Results from audits were fed back to staff through the outpatients department weekly update.

Environment and equipment

- The arrangements for managing waste in the hospital environment kept people safe. Hazard waste systems had been developed to ensure hazardous waste pathways were clear to all staff. A standard operating procedure had been implemented.
- We observed appropriate streaming of hazardous waste. Consulting rooms had a suitable bin with a lid and pedal, containing an orange hazardous waste bag. Sharps bins were labelled and held securely; they were temporarily closed when not in use.
- There continued to be good processes for handling clinical specimens. Specimens were stored appropriately while awaiting collection from the courier.
- Maintenance staff ensured equipment repairs were done in a timely manner. Electrical appliance testing was completed on a rolling programme.
- Personal protective equipment was readily available and seen to be used in the departments. Staff completed a daily checklist, which included a check that sterile instruments were in date. Stock rotation was completed to ensure expired items were not used.
- Reconfiguration of the outpatient areas was underway to enable separate clean and dirty workflows to be implemented. This would address the moving of dirty items through clean areas and so reduce the risk of any cross infection.
- Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) audits were undertaken quarterly. Images were audited in the national audit programme. In February 2018 both MRI and CT audits scored 100%, but the Non-Radiologist Reporting Imaging (NRR) audit only scored 75%. Radiology was not fully functional for a period of time from September 2017, due to the removal of old equipment and installation of new. As a result, some of the audits for the year ending 2017 could not be completed. The new room was operational but work was continuing with the setting up of new baselines.
- In diagnostic imaging all personal protective equipment was available, clean, stored appropriately and subject to annual checks. Appropriate signage was in place to alert staff and patients to areas using imaging equipment.

Good

Outpatients and diagnostic imaging

Assessing and responding to patient risk

- There were systems to assess patients to support appropriate referrals and treatment. Patient safety was initially assessed by an eligibility or exclusion criteria for treating private and NHS patients. For NHS patients, the exclusion criteria was sent to the referral support service so 'choose and book patients' were selected as appropriate. Private patients had eligibility criteria to advise staff, but eligibility was also considered dependent on the patient and the treatment they would receive.
- Patients completed a medical questionnaire before their first appointment in outpatients to allow any risk areas to be identified. All patients allocated for surgery underwent a pre-assessment by nursing staff. Orthopaedic, cosmetic, major gynaecology patients and any patients identified as a concern were booked an appointment two weeks before their surgery for pre-assessment.
- Risk assessments were completed to measure and manage patient risks. Risk assessments included venous thromboembolism, malnutrition universal screening tool, manual handling, waterlow (pressure ulcer risk assessment) and the risk of falls.
- In the event of a medical emergency, staff were aware of their responsibilities to call 999, which was the pathway followed for escalation to the NHS. Resuscitation equipment was not available in the outpatient or diagnostic imaging department; staff would retrieve the resuscitation trolley from the nearby ward. The physiotherapy and cosmetic suite had access to a resuscitation trolley. Both resuscitation trolleys were checked daily and resuscitation equipment was readily available. The mobile diagnostic imaging service provided their own resuscitation grab bag to allow them to respond to an emergency.
- The resident medical officer was trained in advanced life support. All remaining staff had basic life support training.
- Emergency resuscitation scenarios had been completed on the ward and the mobile diagnostic imaging unit. Staff involved received feedback and all departments took learning from the exercises.
- The resuscitation team carried bleeps and there was a minimum team of 3 registered staff at all times. In daytime hours this included the resident medical officer (RMO), matron, the nurse in charge and the anaesthetist. Out of hours this included the RMO and nurse in charge. There were bleepholders in all departments. Staff would respond via the nurse call bell system which linked with an emergency call.

Nurse staffing

- Staff with suitable skills were available in sufficient numbers to support safe patient care. Staffing levels were in line with Royal College of Nursing and National Institute for Health and Care Excellence (NICE) guidance for safe staffing. The number and the type of clinics determined the staffing. Staffing was reviewed regularly by the outpatient manager. Some staff members had specific skills and this was managed on a case by case basis.
- The outpatient department had a full complement of staff with no vacancies. Diagnostic imaging had two permanent radiographers. Agency staff were not used as a contingency workforce, however regular bank staff were used in both the outpatient and diagnostic imaging departments when regular staff were not available.
- In the physiotherapy department, staff told us they had been working short of their full staff complement and had been required to work late on occasions. The hospital confirmed that recent difficulties with staffing had occurred due to some long-term sick leave. Recent recruitment had improved staffing and additional bank staff had been taken on to fill the shortfall. The lack of physiotherapy staff availability to support staff sickness at the weekends was recorded in the outpatient risk register as this sometimes led to a delay in patient discharges.

Medical staffing

- There were sufficient numbers of medical staff to provide the outpatients service. There were 95 consultants with practising privileges with a further 10 held on another register. Clinics were run dependent on consultant availability and therefore medical staffing was a reflection of activity.
- The resident medical officer was provided by an outsourced agency. One resident medical officer was available on site 24 hours a day for the period of their rotation; this was usually one or two weeks. The resident medical officer was available to support the outpatient department, for example one responsibility

of the resident medical officer was to review patient electrocardiograms (ECGs), and if anomalies were identified they would raise this with an anaesthetist to review.

Records

- Patient clinical records were accurate, complete and up to date. We reviewed four sets of patient records and found they were all clearly recorded and contained the required and completed assessments and pathways. Secure email portals were used when sending patient identifiable information.
- Patient clinical records were stored securely onsite. A confidentiality clause was signed by all staff and if a consultant wished to take notes off site they would be referred to the corporate policy covering the security of medical records outside a Ramsay healthcare facility. Removal of records was discouraged.
- Audits were completed to monitor outpatient department record keeping. Compliance with the audit was at 96% on the 22 June 2018 with some issues identified including as the use of medical jargon and some areas not being fully filled in. Actions were shared with the department in the outpatient's weekly update.
- Radiological images and records were stored securely and access was password protected. Images were reviewed by the radiographer at the time they were taken. A second review was undertaken by the consultant. Images were signed in theatre to note they had been seen.
- There were annual radiology audits, with the last being undertaken in July 2017. These included medical records (98% compliance) and operational audits (98% compliance).
- The physiotherapy medical records audit showed that in February 2018 the department had 96% compliance.

Medicines

- Management of medicines was safe. Medicines were stored in locked cupboards and refrigerators. In clinic rooms where medicines were stored, room temperatures were monitored and were within acceptable levels.
- During pre-admission assessment the nurse discussed the patient's current medicines and confirmed the medicines they should have available with them on the day of surgery.
- Pads of prescription stationery were stored securely and their use logged. There were a large number of pads kept in store. There was a reconciliation process that ensured prescriptions were used in a consecutive manner and any missing prescription forms would be detected.
- The hospital pharmacist had been in post for two years and was employed for two and a half days a week. Medicines management audits had been completed hospital-wide and are included in the surgery report above.
- Prescription records and anaesthetic charts were prepared in outpatients and the nursing staff were responsible for recording patient allergies. We saw allergies were recorded on each record.

Incidents

- Incidents were recorded and reviewed to provide learning and prevent reoccurrence. From January to May 2018 there were 94 incidents across the whole hospital. Of these incidents, 53 were clinical patient incidents, 21 were non-patient incidents, 12 related to business continuity, six related to safety and two were identified hazards. The outpatients weekly update included a review of incidents. We looked at three incidents where pre-assessment had not included a discussion about stopping medicines prior to surgery. In one case the surgery had to be cancelled and in two cases it was an identified near-miss of surgery having to be cancelled. Systems had been implemented to prevent reoccurrence after the first event, however the further two incidents still occurred. Further training in pre assessment was provided for staff to prevent reoccurance. A trend was recorded and training provided.
- There had been no requirement for mortality and morbidity reviews. In the event of a death a review would take place at both the clinical governance and medical advisory committee to allow lessons to be learnt.
- There was clear information for reporting radiation incidents. Incidents relating to diagnostic imaging were discussed at local governance meetings and at the radiation protection committee, which met once a year. There had been no recorded incidents requiring external reporting. Providers were required to report any

unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000. Diagnostic imaging services had procedures to report incidents to the correct organisations, including CQC.

- There had been no instances of the duty of candour needing to be applied in outpatients, although examples were given from other areas of the hospital. 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. Staff understood their duty to raise issues and be open and transparent.

Are outpatients and diagnostic imaging services effective?

We do not rate effective.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance and were available to staff electronically. Care pathways were evidence-based and related to the most recent guidance, which was reviewed annually. For example, policies referenced British Association of Day Surgery (BADS) 2011 'Day case and short stay surgery' and National Institute of Health and Care Excellence (NICE) (2016) 'Preoperative tests. The use of routine preoperative tests for elective surgery'.
- Pathway documents guided staff to follow a set plan of care and treatment. Template documents included a pre-assessment document, cataract care pathway, surgical day case pathway and hip replacement care pathway.
- A patient journey audit had been implemented. The audit aimed to confirm relevant documentation was completed and in accordance with NICE guidance. In June 2018 the audit scored 92% compliance.
- Referrers and radiographers could access an electronic referral guidance tool written by the Royal College of Radiologists. The diagnostic imaging department had adopted the Society and College of Radiographers pause and check safety procedure.
- A magnetic resonance imaging (MRI) and computed tomography (CT) audit was carried out as part of the audit programme to ascertain compliance with the employer's procedures and referral criteria. This was measured in February 2018 with 100% compliance. All radiologists were subject to a reporting discrepancy audit as required by the Royal College of Radiologists. Work was being undertaken to ensure all X-rays had a formal comment included as part of their report.

Nutrition and hydration

- Patients' nutritional and hydration needs were considered and used to inform decision making. All aspects of nutrition and hydration were discussed as part of the pre-assessment review. During pre-assessment, the nurse confirmed the patient's fasting instructions in preparation for surgery.
- Weight and height were assessed as part of a pre-assessment review to calculate the patient's body mass index (BMI). This was used to help determine the malnutrition universal screening tool (MUST) score, to identify any patient risks. The patient's MUST score would subsequently be monitored on the ward on admission and through to discharge.
- Drinks were available in the department waiting areas. Hot drinks were payable for NHS patients. A water fountain was available. Patients waiting for long periods of time in the department would be offered a complimentary drink and arrangements could be made to provide patients with food, particularly if a patient had health needs which required set times of eating.
- Specialist dietary support was available. There was a specialist bariatric dietitian that worked with relevant patients undergoing surgery. They worked when required and held a substantive post elsewhere.

Pain relief

- Pain management was discussed and recorded as part of pre-assessment. Patients were made aware of the pain anticipated following surgery and encouraged to ensure adequate pain relief was available at home following discharge.
- The hospital did not have a specific pain management lead but could access the pain management team at the local acute hospital trust should they require support. A private pain management clinic was available and patients could be referred to their service.

Patient outcomes

Good

Outpatients and diagnostic imaging

- Patient outcomes were not monitored against external benchmarks in the outpatient department. Internal audits, including infection control, patient journey and environmental audits, were completed and showed scores between 90% and 100%. Outcomes were monitored in the outpatient follow-up appointment in line with the surgical treatment received.
- Cancellations rarely happened in the outpatient department. When a list had to be cancelled this was reported on the internal incident system. During an episode of snow in 2018 the list was cancelled and patients were contacted the evening before to advise them of the cancellation. We saw from data supplied that 8.3% of cancellations were due to outpatient changes.
- There were no external physiotherapy patient outcomes to measure changes in patient health and quality of life. Physiotherapy muscular skeletal (MSK) outcome measures were only fully implemented in September 2017. The information was being collated at a corporate level. The report and findings were planned to be analysed and released after 12 months of implementation. We looked at the internal physiotherapy audits for aspects of the patient journey and saw they had scored 99% overall for the related aspects of care.

Competent staff

- An overview of staff training and competences informed managers of staff skills and any updates needed. Staff received training to allow them to develop personally. All staff had practical skills competency training and one nurse had attended a bariatric study day to improve their skills and knowledge to work with bariatric patients.
- A process was used to flag pending registration and revalidation for staff registered with the General Medical Council, Nursing and Midwifery Council or the Health and Care Professions Council. We were informed the electronic health roster system would not allow staff to be rostered for duty if their registration information was out of date.
- Staff received personal development reviews to set objectives and identify training needs. This formed the annual appraisal. Staff appraisals in May 2018 showed a completion rate of 83%.
- Medical staff were monitored to ensure consultants were skilled, competent and experienced to perform in their hospital. The medical advisory committee (MAC) were responsible for reviewing all prospective new consultants to the hospital and, following that review, granting consultant practising privileges. The consultants working under practising privileges were asked to provide evidence of the work they carried out at local acute hospital trusts or other independent healthcare providers. Consultants shared appraisals completed at the trust they also worked at. One consultant worked exclusively in private health care and had their appraisal completed by Ramsay senior management.
- The competency of the resident medical officer was monitored by the providing agency who confirmed their skills and experience.
- Continual professional development was supported by some aspects of specialist learning. Bariatric competencies had been completed by senior outpatient staff and visual fields training had been completed by four staff.

Multidisciplinary working

- Staff worked well between departments and external services. All necessary staff were involved in assessing, planning and delivering people's care and treatment. This meant patients could have multiple visits in one appointment to save return visits.
- There were good links with GP services. A GP liaison officer represented the hospital to build strong links with the local GPs and practice managers. Relationships were also formed with the local acute hospital trust to provide additional support when needed.
- The radiology service manager and their team had a working relationship with referrers and were able to challenge requests that may be unjustified. There was a process for getting urgent advice on urgent unexpected findings and they had good links with the local acute hospital trust for advice and support.

Seven-day services

- Outpatients and diagnostic services was mostly a five-day service. The outpatient department was open Monday to Friday, 7.30am to 8pm. There were some instances when Saturday clinics were also held.
- The physiotherapy department was a five-day service, open Monday to Friday. Physiotherapists were also available at weekends to work on the wards.

Good

Outpatients and diagnostic imaging

- Pharmacist support was available two days a week, with plans for a future expanded service to provide further cover. Outside of these working days the Ramsay Healthcare group pharmacist could be contacted for advice.
- The diagnostic imaging department was a four-day service open Monday to Thursday. Radiology staff were employed on a flexible working contract in order to ensure all clinics and theatres were covered and staff were able to be flexible with hospital demands. Emergency cover was provided by an on-call rota with access to a radiologist out of hours for urgent reporting.

Health promotion

- Health promotion was considered as part of the outpatient service. Health promotion posters were seen in the department. The hospital was running a competition to promote health in staff, prizes were given to the person with the highest step count.

Consent and Mental Capacity Act

- All staff spoken with demonstrated an understanding of consent and decision making requirements in line with legislation and guidance.
- The consent process started in the outpatient department and was clearly completed and recorded. Stage one consent forms were completed in outpatients to record patients' agreement to investigation or treatment and included intended benefits and significant, unavoidable or frequently occurring risks. Stage one was signed by both the consultant and the patient. On admission consent was confirmed again (stage two) by a health care professional prior to anaesthesia or treatment.
- We were unable to see the two stage consent for cosmetic surgery, because no cosmetic surgery patients were in the hospital on the day of our inspection. For cosmetic surgery, consent should be obtained in a two-stage process with a 'cooling off' period of at least two weeks between stages to allow patients to reflect on their decision. If this is not possible, good reasons should be documented in the patient's notes. This is in line with the Royal College of Surgeons professional standards for cosmetic practice 2013. Reassurance was provided by the senior staff that the two-step process was now correctly completed and we saw evidence of completion on the cosmetic records audit.
- Consent was obtained from patients in line with the clinical photography corporate policy. A new service level agreement for clinical photography had been implemented to support staff. The camera was held in the outpatient manager's office. A photograph log had been implemented to record all pictures taken. Patient photographs in the cosmetic suite were stored and managed securely on the computer in line with corporate policy. There continued to be no assurance to confirm the photographs taken by consultants on their own cameras were held securely and images were deleted from the device or memory card immediately after they had been printed or sent to the patient.
- Consent audits were part of the audit programme and completed quarterly. We reviewed the audits from April 2017 to April 2018 and saw 100% compliance had been achieved.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership

- Managers of the hospital had the skills and experience needed to lead effectively. Staff were positive about access to, and visibility of, their departmental manager.
- The matron did not work clinically and comments from staff indicated they were not always visible but were accessible if needed. Staff spoke positively about the outpatient manager and said they felt able to raise any issues and felt listened to.
- Staff said the hospital management team were accessible.
- Staff survey results for 2018 provided a varied response with low scores for some leadership areas. For a question about the corporate team listening and acting on staff views and concerns the hospital scored 16%. This was a deterioration on the previous years score of 34%. Only 28% of staff felt supported during periods of change and 29% felt the corporate team communicated what staff needed to know. The question about the senior management team taking the views and opinions of staff seriously scored 29%. This was another deterioration in score as the previous year had scored

49%. Staff were asked if they felt able to communicate upwards through the company and 56% of staff felt they could. The lower scores had been identified for department leads for discussion and actions to take the issues forward. This work was currently ongoing.

Vision and strategy

- The hospital followed the corporate set of values 'The Ramsay Way'. These included five values and staff were aware of them. Since our last inspection local values had been developed with the input of the heads of each department. These values were visible in the departments and staff demonstrated knowledge of them. One staff member advised these were used as part of their appraisal as a guide.
- There was a local clinical strategy developed by the matron and department leads to engage staff in the hospital.

Culture

- An open and honest culture was promoted. Staff in the outpatient department enjoyed working at the hospital and this was reflected by how long many of the staff had worked there. However, the scores from the 2018 staff survey showed areas of management scored poorly with only 49% of staff recorded there was a positive and inclusive atmosphere within Ramsay Healthcare.
- Staff in the diagnostic imaging department felt there was a great working culture within the department. In general, relationships were positive and staff felt they interacted well and knew their roles.
- Staff had access to a well-being check from a third party occupational health service, which was part of the Ramsay staff benefits. Staff could access additional services to support them, such as confidential counselling via the Ramsay benefit programme.
- Private patients were provided with terms and conditions of the services being provided and the amount and method of payment fees.

Governance

- There was an effective governance framework to support the delivery of good quality care.
- The senior management team oversaw all committee groups within the governance structure. Senior management team met weekly and minutes were kept as an audit trail of decisions made.
- The clinical governance committee met every two months. Meeting minutes recorded areas of discussion, which included complaints and incidents, review of reports from clinical committees, guidance and legislation, policy update, audit update and risk register update. A monthly governance report was sent to corporate governance.
- The Medical Advisory Committee (MAC) met quarterly. The committee looked at some clinical or quality audits. There was consultant representation across all specialities and included input from radiology.
- Head of department meetings were held monthly and discussions were held around hospital activity, financial forecast, agency usage, new legislation, alerts, staff sickness and turnover, training, significant events, complaints, risk register and audit.
- Daily morning briefings included representation from each department; this was mostly head of departments. Staff felt the meetings were effective and we saw evidence of information being cascaded to staff by heads of department in the form of an information folder after the meeting
- Departmental meetings were held regularly. These meetings provided an opportunity to receive feedback from the head of department meetings. These meetings were recorded for those not able to attend.
- The radiology lead attended a regional team meeting where all diagnostic leads were involved, including the head of diagnostics. An annual report was produce by radiology to demonstrate compliance around the Ionising Radiation (Medical Exposure) Regulations and Radiation Protection. This report included any areas required to be addressed.
- There was a governance procedure for managing and monitoring transfer of care agreements with third party providers. For example, the agreement for transfer of critically ill patients with the local acute NHS hospital trust .

Managing risks, issues and performance

- There was a systematic programme of clinical and internal audit to monitor quality. We saw evidence of completed audits and action plans to address any shortfalls. The audit plan appeared comprehensive. Managers were using the audit system to monitor and improve performance.
- Arrangements for identifying and managing risks with mitigating actions were managed on a risk register.

There was a corporate risk register and departmental risk registers to allow risks to be recorded and managed at a local level. Risk assessments were completed at departmental level and we saw evidence these were reviewed annually or when changes needed to be reflected.

- The risk register recorded risks and actions, but these were not all addressed in a timely manner. The provider had identified on the outpatient risk register that a lack of cyber lab access limited access to results. This meant there was a potential risk of duplicating tests or tests being missed. This had an identified tolerance level of not acceptable. However, this had been identified on the risk register in February 2017 and was last reviewed in April 2018. This was a risk to patients which had not been addressed in a timely manner.

Managing information

- Arrangements for advertising and promotional events were in accordance with advertising legislation and professional guidance. The hospital used literature, websites and posters for promotion of the service.

Engagement

- There was engagement of the public and patients in the outpatient and diagnostic service, and hospital-wide. The friends and family test was used to inform the provider about the service provided. An annual report was written, which included benchmarking against other providers and any year-on-year improvements. In the April 2018 audit report we noted 100% of respondents were satisfied overall with the care received and 96% were likely to recommend the service.
- The hospital held regular open events which offered the general public an opportunity to visit the hospital and meet with consultants to privately discuss specific areas of interest. An open day was held in May 2018 which focussed on marketing and provided free consultations. Events held included orthopaedics, cosmetic, mole treatment, dermatology, headache and pain management.
- The general manager told us they were looking for patients to be involved in a customer focus group for staff and patients. This would be looking for feedback and identifying trends. As yet no patients had been identified. Minutes were available from the last meeting in March 2018, which showed areas discussed included reviews of the environment and new work being undertaken.
- There was also a quality survey undertaken by head office. Questionnaires were sent to patients and results benchmarked against other Ramsay Hospitals. Feedback was provided that patients said they were not communicated with over results at the outreach clinics. As a result training was provided to staff about communication and managing realistic patient expectation.
- Patient satisfaction was gathered and reported in an annual report. The response scores were measured against the previous year. Responses varied dependant on the question with some areas showing improvement. For example, in 2016, 90% of patients responded that they were told how to take medicine in a way they could understand. In 2017, 100% felt they had been told in a way they could understand. Some scores had dropped. For example, in 2016, 100% of patients felt staff explained risks and benefits in a way they could understand. In 2017, 92% felt this.
- Outpatient areas each had their own annual satisfaction report. Endoscopy, radiology and physiotherapy each had their satisfaction scores recorded. The outpatient and diagnostic service received feedback from patient comments via hot alerts. This included comments made with the friends and family test. Hot alerts provided important updates to staff via email and on paper.
- Staff were engaged through the staff survey with areas identified within this report.

Learning, continuous improvement and innovation

- Changes were seen as a result of patient engagement. We saw 'you said, we did' posters, which demonstrated patients' comments had been translated into actions. For example, extra hanging hooks for clothes in the Ambulatory Care Unit.
- Documentation to promote a smooth patient journey had been developed. Pre-assessment flowcharts to assist clinical decision making had been implemented. Anaesthetic flowcharts had also been developed to assist clinical decision making about when to refer patients.

Good

Outpatients and diagnostic imaging

- There had been the introduction of a GP service within the department. This development was in its infancy and no outcomes were yet available to measure its success. This enabled patients to see a general practioner for a private consultation.
- The hospital staff were awaiting the roll out of an electronic record system, to include patient medical records, billing and pharmacy, and improve access to information. There had been development on this since our last inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Ensure the lack of permanent theatre staff does not impact on procedures being undertaken. We were made aware of the fragility of theatre staffing and the direct impact on patients as procedures sometimes had to be cancelled.
- Cosmetic surgery practice was not monitored to ensure practice was in line with the Professional Standards for Cosmetic Practice – Cosmetics Surgical Practice Working Party, Royal College of Surgeons (RCS) Professional Standards.
- Review the process for deciding which incidents have an investigation. A consistent approach to incident investigation was not formalised to ensure a standardised approach was taken.
- Review on-call arrangements to ensure they are well-organised to ensure patient safety and ensure a clear decision making processes.
- Ensure the photographs taken by consultants on their own cameras are held securely and images are deleted from the device or memory card immediately after they have been printed or sent to the patient.
- Ensure the risk register recorded risks and actions are addressed in a timely manner.
- The staff survey results for 2018 showed that some areas of senior and corporate management scored poorly. Ensure the areas highlighted as poorly scored are reviewed an addressed.