Oaklands Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Oaklands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 17 inpatient beds. Facilities include four operating theatres, one inpatient ward, a day case unit and X-ray, outpatient and diagnostic facilities. The hospital also has plans to open a two-bedded level two facility to accommodate patients with a higher level of clinical need, but not requiring a full intensive care facility; however, this was not in use at the time of our inspection

The hospital provides surgery and outpatients and diagnostic imaging. We inspected both of these services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 4 and 5 October 2016 and an unannounced visit to the hospital on 13 October 2016.

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

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

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

We rated this hospital as inadequate overall. We served warning notices against the provider and the registered manager following a breach of Regulation 12 Safe care and treatment (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). This was because there was a failure to assess the risks to the health and safety of patients and to take action to mitigate such risks. The hospital also failed to ensure staff had the necessary qualifications, competence, skills and experience to provide safe care and treatment. Medicines were not managed properly or safely. You can read more about it at the end of this report.

We also served warning notices against the provider and the registered manager following a breach of Regulation 17 Good governance (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). This was because systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the services provided. There was inadequate management of the risks relating to the health, safety and welfare patients who may be at risk. You can read more about it at the end of this report.

- Safety was not a sufficient priority. Standard operating procedures and processes designed to keep people safe were not always followed.
- Staff did not always assess and mitigate risks to patients' safety. This included poor compliance with the completion of important risk assessments.
- Patients were at risk of avoidable harm during surgery, because on some occasions anaesthetists did not provide them with the expected level of care.
- Most staff in the theatre and in the recovery area did not have the correct level of training to care for patients in the event of a respiratory or cardiac arrest.
- Medicines and other substances were not always stored safely. Controlled drugs were not managed safely and were managed contrary to legislation and national guidelines.
- Records were poorly maintained and lacked key information, including details of individualised patient risk assessments.

Summary of findings

- Senior staff had little assurance that the temporary staff employed had the relevant qualifications, experience and competence to undertake their role. Systems and processes to check the competence and qualifications of these staff were not robust.
- There were substantial and frequent staff shortages, which resulted in an over-reliance on agency and bank staff to supplement the staffing establishment. The hospital did not have adequate systems and processes in place to check the skills and competencies of these staff.
- Governance and risk management systems were not used effectively to ensure the safety of patients and the quality of care delivered.
- Staff, including senior managers, did not recognise, assess and mitigate risks appropriately.
- Action was not always taken when areas of serious concern were identified and as a result poor and unsafe practice was allowed to continue.
- There was a culture of fear within theatres, which resulted in staff not challenging unsafe behaviours.
- Mandatory training rates were 63.9%, which was significantly below the hospital target of 100%. This included very low numbers of staff undertaking mandatory training in safeguarding children and adults. An example of this was that no staff in the theatre areas had completed level two safeguarding adults training.
- Staff were not fully aware of their responsibilities in relation to the Mental Capacity Act (2005) and did not receive training in relation to this.
- Staff were unaware of the hospital's dementia strategy and only 34.9% of staff had received training on dementia.
- There were no specific arrangements in place to make reasonable adjustments or considerations for patients with a learning disability or living with dementia.
- The hospital patient led assessment of the care environment (PLACE) score for the environment for patients with a disability was lower than the England average of 81%.
- Complaints were sometimes responded to in a defensive way and improvements in the complaints handling process were not yet embedded.
- There was no credible local vision or strategy for the service and there was a lack of robust governance and risk management systems.
- Staff and the public were not engaged sufficiently.

However,

- Staff were aware of how to use the incident reporting system and feedback from incidents was consistent.
- Infection rates were low. Clinical areas and waiting areas were visibly clean and there were systems in place to prevent the spread of infections.
- There was appropriate equipment to safely provide care and treatment for patients in the departments. The equipment was well maintained and tested to ensure its safety and effectiveness.
- Medical staffing was sufficient and patients received care according to national guidelines from organisations such as the National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges.
- The hospital participated in national audits. Findings from patient reported outcome measures (PROMs) showed most patients had a positive outcome following their care and treatment.
- There was good multidisciplinary working between consultants, nursing staff and allied health professionals.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- The hospitals Friends and Family test showed that patients were happy with the care they received.
- There was sufficient capacity for patients to be seen promptly and be cared for in the most appropriate environment.
- Between July 2015 and June 2016, the hospital consistently met the national standard of 92% of incomplete pathways for patients beginning treatment with 18 weeks of referral.
- The hospital met the indicator of 90% of admitted NHS patients beginning treatment within 18 weeks of referral for each month between June 2015 and June 2016.

Summary of findings

- Staff had a good knowledge of the complaints process so could direct patients if they had a complaint about the service.

In surgery:

- The senior managers responsible for theatres did not effectively manage or lead the area.
- Local audit findings were not always acted on to ensure necessary improvements.

However,

- Nutrition, hydration and pain relief was managed effectively.
- Staff spoke positively about the inpatient ward manager and matron.

In outpatients:

- Only 50% of staff in the outpatient department had completed level two safeguarding training for children.
- We found equipment in the paediatric resuscitation trolley, which was outside of the manufacturer's recommended expiry date. This demonstrated that adequate checks were not being carried out.
- We found that not all clinical waste was being properly stored in the outpatient department, as a sharps bin in the clean utility room was being used for the disposal of contraceptive coils.

However,

- The departments kept a record of the competencies of all staff and new staff underwent an induction programme to prepare them for working at the hospital.
- Staff were positive about the leadership of the departments and told us local managers were supportive of them.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two warning notices that affected the surgical and outpatients and diagnostic imaging departments. Details can be found at the end of the report.

Ellen Armistead
Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Inadequate** 	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 inadequate in the safe and well-led domains and requires improvement in the effective and responsive domains. We rated caring as good. • Safety was not a sufficient priority across the surgical services. Standard operating procedures and processes designed to keep people safe were not followed. • Staff did not always assess and mitigate risks to patients' safety. This included poor compliance with the completion of important risk assessments. • Patients were at substantial risk of harm during surgery, because anaesthetists did not provide them with the expected level of care. • Systems and processes to check the competence and qualifications of bank and agency staff were not robust. There was an over-reliance on these staff due to substantial staff vacancies • There were no specific arrangements to make adjustments or considerations for patients with a learning disability or for those who were living with dementia. Only 32.3% of staff had received dementia training. • The response to complaints was sometimes defensive. • Governance and risk management systems were not used effectively to ensure the safety of patients and the quality of care delivered. • Staff including senior managers did not recognise, assess and mitigate risks appropriately. • There was a culture of fear within theatres, which resulted in staff not challenging unsafe behaviours. However,

Summary of findings

- The services participated in national audits. Findings from performance reported outcomes measures (PROMs) showed most patients had a positive outcome following their care and treatment.
- Staff treated patients with kindness, dignity and respect and provided care to patients, while maintaining their privacy, dignity and confidentiality.
- There was sufficient capacity in the wards and theatres to ensure patients admitted for surgery could be seen promptly and receive the right level of care.

Outpatients and diagnostic imaging

Requires improvement 

Outpatients and diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as requires improvement because;

- Staff in the outpatient department had completed only 49% of the modules of mandatory training that were appropriate to their roles. Only 50% of staff in the outpatient department had completed level two safeguarding training for children.
- Adequate checks were not always carried out on essential equipment and not all clinical waste was being properly stored in the outpatient department.
- Only 37.5% of staff in the outpatient department had received training on dementia awareness.
- Governance and risk management systems were not used effectively to ensure the safety of patients and the quality of care delivered.
- Staff including senior managers did not recognise, assess and mitigate risks appropriately.

However,

- The services followed national guidelines, legislation and standards to ensure that practice was evidence based.

Summary of findings

- The services kept a record of the competencies of all staff and new staff underwent an induction programme to prepare them for working at the hospital.
- Staff were caring and compassionate to patients who used the departments. All the patients we spoke with were positive about the way they had been treated by staff in all the departments.
- Services had been planned to meet the needs of local people. Staff informed patients about delays to clinics and patients said they were seen promptly in the departments when they had appointments.
- Between July 2015 and June 2016, the hospital consistently met the national standard of 92% of incomplete pathways for patients beginning treatment with 18 weeks of referral.
- Staff were positive about the local leadership of the departments.

Summary of findings

Contents

Inadequate

Oaklands Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Oaklands Hospital

Oaklands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1991. It is a private hospital in Salford, Greater Manchester. The hospital primarily serves the communities of the Salford and Greater Manchester areas. It also accepts patient referrals from outside this area.

The hospitals registered manager is Helen Rocca, who has been in post since July 2008. The nominated individual is Vivienne Heckford.

We carried out an announced inspection of Oaklands Hospital on 4 and 5 October 2016. We carried out the unannounced inspection on 13 October 2016.

Our inspection team

The inspection team was led by a CQC lead inspector,two other CQC inspectors and three specialist advisors with expertise in surgery, theatres and diagnostic imaging. The inspection team was overseen by an inspection manager.

Information about Oaklands Hospital

Oaklands Hospital provides outpatient consultations, physiotherapy, diagnostic imaging, day surgery and inpatient surgery for NHS funded and private patients across a range of medical and surgical specialities including orthopaedic, cosmetic, general and gynaecological surgery. The hospital has one inpatient surgical ward with 17 beds, an eight-bedded day case unit and four theatres, three of which have laminar flow. The hospital provides a range of diagnostic imaging services including X-ray, DEXA scanning (a type of X-ray that measures bone mineral density) and ultrasound. The hospital is registered to provide the following regulated activities:

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

We inspected two core services at the hospital: surgery, and outpatients and diagnostic imaging.

During the inspection we visited the ward, theatres, outpatients, physiotherapy and diagnostic imaging departments. We interviewed the registered manager, the controlled drugs accountable officer and the chair of the medical advisory committee. We spoke with 38 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We also held a focus group where staff could share their experiences of working at the hospital. We observed care and treatment and spoke with 11 patients. We reviewed 23 sets of patient records and reviewed staff files and competencies.

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 has been inspected seven times and the most recent inspection took place in November 2014, which found that the hospital needed to improve standards of cleanliness and hygiene and associated audits and checks. We found these practices had improved during this inspection.

In the reporting period July 2015 to June 2016, there were 5,352 inpatient and day case episodes of care recorded at the Hospital; of these 92% were NHS-funded and 8% other funded.

Nineteen percent of all NHS-funded patients and 15% of all other funded patients stayed overnight at the hospital during the same reporting period.

Summary of this inspection

There were 27,868 outpatient attendances in the reporting period; of these 93% were NHS- funded and 7% were other funded.

One hundred surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. There was one regular resident medical officer (RMO), who worked on a weekly rota along with RMOs supplied by an agency. Oaklands employed 18.9 whole time equivalent (WTE) registered nurses, 12 WTE healthcare assistants and operating department practitioners and a team of administrative, housekeeping and facilities staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the matron.

Between July 2015 and June 2016, there were no never events at the hospital. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented. There were a total of 221 other clinical incidents during this time. Of these, 196 resulted in no harm, 21 in low harm and 4 in moderate harm. None had resulted in severe harm and there had been no deaths at the hospital during this time.

There were no incidences of hospital acquired methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (c.diff) or e-coli between July 2015 and June 2016.

The hospital had received 60 complaints between July 2015 and June 2016. We received 11 complaints about the hospital and one whistleblowing concern.

A mobile computerised tomography (CT) scanner and a mobile magnetic resonance imaging (MRI) scanner visit the hospital each week. These are operated by another provider and were not inspected as part of the inspection of Oaklands Hospital.

Services provided at the hospital under service level agreement:

- Pharmacy
- Pathology and histology
- RMO provision
- Medical records storage
- Medical photography

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?

Inadequate

We rated safe as inadequate because:

- Safety was not given sufficient priority across the surgical services. Medicines and other substances were not stored safely and this posed a risk to patient safety.
- Controlled drugs were not managed safely and were managed contrary to legislation and national guidelines.
- Standard operating procedures and processes designed to keep people safe were not followed. Senior staff were aware of some of these issues and had not taken steps to mitigate the risk these issues posed to patients.
- Staff told us there were occasions when the anaesthetist responsible for keeping patients safe during surgery left the operating theatre for periods of up to 20 minutes.
- Staff in the theatre and in the recovery area did not have the correct level of life support training to care for patients in the event of a respiratory or cardiac arrest.
- Records were poorly maintained and lacked key information, including details of individualised patient risk assessments.
- Staff did not always assess and mitigate risks to patients' safety. This included poor compliance with the completion of important risk assessments. Preoperative anaesthetic assessment records were incomplete or missing in a number of cases.
- There were substantial and frequent staff shortages in theatres and this had resulted in an over-reliance on agency and bank staff. Systems and processes to check the competence and qualifications of these staff were not robust.
- Training rates for mandatory training across the hospital were 63.9%, which was significantly below hospital target of 100%.
- Safeguarding adults and children training figures were significantly below the hospital target of 100%.
- The 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist were not completed in all cases.
- We found equipment in the paediatric resuscitation trolley which was outside of the manufacturer's recommended expiry date, which demonstrated that adequate checks were not being carried out.
- We found that not all clinical waste was being properly stored in the outpatient department.

However,

Summary of this inspection

- Staff had a good understanding of how to report incidents, and gave examples of lessons learned and improvements made.
- Clinical areas and waiting areas were visibly clean and there were systems in place to prevent the spread of infections.
- Infection rates were low within the surgical services and staff observed appropriate measures to protect patients from avoidable infections.
- Medical staffing was sufficient and patients had access to suitably qualified doctors when required.
- There was appropriate equipment to provide care and treatment for patients in the departments. The equipment was mostly well maintained and tested to ensure its safety and effectiveness.
- In the outpatient and diagnostic imaging departments, staff knew how to respond to deteriorating patients. Training, systems and processes were in place, to ensure risks to these patients were minimised.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Audits were carried out in line with a corporate audit plan, however, necessary actions in response to areas of poor compliance and to improve patient outcomes were not always followed up or actioned.
- We were not assured that staff had the correct skills, competencies and qualifications to care for patients effectively. Systems to ensure that temporary agency and bank staff had the competencies and skills to care for patients were not robust.
- There were gaps in the management and support of staff including low appraisal rates in all areas, including one staff group, which had an appraisal rate of 0%.
- Staff were not fully aware of their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS) and had not received training in these subjects.
- Staff were required to undertake training on informed consent, however, the uptake level for this training was 0% across the service.
- The number of unplanned transfers to other hospitals was higher than in other independent hospitals.

However,

- Patients received care in line with national guidelines from organisations such as National Institute for Health and Clinical Excellence (NICE) and Royal Colleges'.

Summary of this inspection

- The services participated in national audits. The findings from patient reported outcomes measures (PROMs) showed most patients had a positive outcome following their care and treatment.
- The rate of unplanned readmissions was similar when compared to national averages and to other independent hospitals that we hold this information for.
- Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital). Practising privileges were reviewed regularly by the medical advisory committee.
- Nutrition and hydration was managed effectively and pain relief was provided when required.
- There was good multidisciplinary working between consultants, nursing staff and allied health professionals.

Are services caring?

Good

We rated caring as good because:

- Staff were caring and compassionate to patients. They treated them with kindness and respect. All the patients we spoke with were positive about the way they had been treated by staff in all departments.
- One hundred percent of patients who completed the NHS friends and family test over three months said they were likely or extremely likely to recommend the hospital to friends and family. However, only 1% of patients responded to this test.
- Patients were involved in decisions about their care and treatment and told us they were given adequate information before, during and after treatment.
- Staff provided emotional support to patients and recognised the importance of involving families or carers in their care.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- All staff we spoke with, apart from the matron and registered manager, were unaware of the hospitals dementia strategy.
- Only 34.9% of staff had received training on dementia awareness.
- There were no specific arrangements to make reasonable adjustments or considerations for patients with a learning disability or patients who were living with dementia.
- The hospital PLACE score for the environment for patients with a disability was lower than the England average of 81%.
- Only 65% of staff had received equality and diversity training.

Summary of this inspection

- Complaints were sometimes responded to in a defensive way and improvements in the complaints handling process were not yet embedded.

However,

- There was sufficient capacity in the wards and theatres to ensure patients admitted for surgery could be seen promptly and be cared for in the most appropriate environment.
- Between July 2015 and June 2016, the hospital consistently met the national standard of 92% of incomplete pathways patients beginning treatment with 18 weeks of referral.
- The surgical services met the indicator of 90% of admitted NHS patients beginning treatment within 18 weeks of referral for each month between June 2015 and June 2016.
- Services had been planned to meet the needs of local people. The longest patients waited for an appointment was two weeks. There was flexibility in outpatient appointment times and appointments were available in the evenings.
- Staff informed patients about delays to clinics and patients said they were seen promptly in the departments when they had appointments.
- Staff had a good knowledge of the complaints process, so could direct patients if they had a complaint about the service. Complaints about the service were investigated and lessons learnt were shared with some staff.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Governance and risk management systems were not used effectively to ensure the safety of patients and the quality of care delivered.
- Staff, including senior managers, did not recognise, assess and mitigate risks appropriately.
- Action was not always taken when areas of serious concern were identified and as a result poor and unsafe practice was allowed to continue.
- Staff had a poor knowledge of the hospital and Ramsay Health Care UK vision and strategy.
- The senior managers responsible for theatres did not effectively manage or lead the area.
- There was a culture of fear within theatres, which resulted in staff not challenging unsafe behaviours.
- Staff and the public were not engaged sufficiently.
- There were no areas of innovation.

However,

Summary of this inspection

- Staff spoke positively about the matron and inpatient ward manager and told us they were visible.
- The hospital was engaging with staff and patients, for example by completing a staff survey and the friends and family test. However, participation for the friends and family test was only 1%.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

We inspected, but did not rate effective in outpatients and diagnostic imaging, as we are not currently confident we are collecting sufficient evidence to rate this key question.

Inadequate

Surgery

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

Are surgery services safe?

Inadequate

Incidents

- All staff had access to the hospital's electronic incident reporting system. Staff were able to demonstrate how they would report an incident using this system.
- Staff received training on how to use the system as part of their induction to the hospital.
- Managers reviewed all incidents and we saw evidence that appropriate responsive actions were taken as a result of incidents.
- Staff told us they received meaningful feedback relating to any incidents they raised. This feedback included what action had been taken.
- Staff were aware of the types of incident they should report and were able to give us recent examples where they had raised incident reports. One example of this was a patient being discharged with the incorrect discharge information leaflet. As a result, the discharge information sheets were changed to make it clearer at a glance which condition they related to.
- Lessons learned from incidents and complaints were shared with staff during monthly lessons learnt forums and team meetings and were also available on a shared drive on all hospital computers.
- The surgical services reported 196 incidents for the period June 2015 to July 2016. This accounted for 71% of the total incidents reported for the hospital. The rates of harm reported by the hospital were lower when compared to services of a similar nature and size. As an example the surgical service reported 0% of incidents resulted in severe harm; this was compared to an average of 0.8% in a group of services of a similar size and nature. Data provided by the service showed that 88.7% of all reported incidents resulted in no harm. This suggested a positive reporting culture.

Clinical Quality Dashboard or equivalent

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), should be monitored on a monthly basis.
- The surgical services were recording and monitoring some data in line with this initiative. This included monitoring rates of VTE, pressure ulcers and falls. This information was collated using the incident reporting system and fed into managerial meetings and the matron's quarterly briefings.
- There had been three VTE's reported in the period June 2015 to July 2016. These incidents were investigated using a root cause analysis and key actions were set out to reduce the risk of reoccurrence.
- Between April and June 2016, data showed there had been no reported falls or pressure ulcers in the surgical services.
- The service undertook an audit to measure compliance with the use of the urinary catheter care bundle in December 2015. This showed the service was 100% complaint with all standards measured at this time. These standards included documentation of the reason for insertion, management of the catheter and removal.

Cleanliness, infection control and hygiene

- There had been no cases of methicillin-resistant staphylococcus aureus (MRSA) bacteraemia infections,

methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia infections or clostridium difficile (C.diff) infections at the hospital between June 2015 and July 2016.

- Surgical site infection rates were low and each infection was subject to a root cause analysis investigation. Between July 2015 and July 2016, the service undertook 147 primary hip replacement operations. In one case a patient developed a surgical site infection; this equates to an infection rate of 0.7%. In the same period the service undertook 328 primary knee replacement surgeries and in two cases patients developed a surgical site infection. This equated to an infection rate of 0.6%.
- The ward and theatres we inspected were visibly clean.
- Theatre management were unable to tell us where cleaning lists and schedules were held. However, the matron for the service confirmed that cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. We saw these being used in practice and they were completed appropriately.
- There were sufficient numbers of hand wash sinks and hand gel dispensers.
- Staff were aware of current infection prevention and control guidelines and were able to give us examples of how they would apply these principles.
- Staff were observed using personal protective equipment, such as gloves and aprons, and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed 'arms bare below the elbow' guidance.
- Most staff followed procedures for gowning and scrubbing in the theatre areas. We observed a staff member who was in full scrub gowning leave a theatre area and enter another theatre in the same gown and personal protective equipment. We then observed the same member of staff re-enter the original theatre with the same gowning and personal protective equipment. This posed a risk of cross-infection between the two theatres. This was highlighted to theatre management and matron, who dealt with the issue immediately.
- The service undertook early screening for infections including MRSA during patient admissions and preoperative assessments. This meant staff could identify and isolate patients early to help prevent the spread of infections.
- Theatre management told us they were unaware of any infection control audits which were undertaken in the theatre areas. However, when we spoke with the infection control lead nurse, they provided us with audit results for handwashing and environmental audits in the theatre and ward areas. The results of these audits showed consistently high rates of compliance of between 95% and 100% in both the theatre and ward areas.
- Patient-led assessment of the care environment (PLACE) is a measure of the care environment in hospitals which provide NHS care. The assessments are undertaken by local people who visit the hospital and look at different aspects of the care environment. The hospital scored 100% in the PLACE for cleanliness between February and June 2016. This was higher than the England average of 98% for independent hospitals.

Environment and equipment

- Equipment on the wards and in theatre areas was visibly clean and appeared to be well maintained.
- Staff carried out regular checks on key pieces of equipment in all areas. Emergency resuscitation equipment was in place and records indicated it had been checked daily in all areas, with a more detailed check carried out weekly as per the hospital policy.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Electrical safety testing was up to date for all devices we checked in the theatre and ward areas.

Medicines

- Medicines were not being safely and effectively managed within the surgical services. We found issues relating to the safe management of medicines within both the theatre and ward areas.
- In the ward area, we found that numerous boxes and loose strips of tablets were being kept in a plastic basket inside a medication cupboard. Staff told us they would dispense and carry out their medication round from this basket. Within this basket we found strips of a medication which had been cut from main strips of the medication. This meant they lacked expiry dates and serial numbers. It is important for medications to have a clear expiry date, because if a medication is past its expiry date, it can affect the efficacy of the medication. It is also important that serial numbers are clearly visible

and not cut off. This is because in case of a recall by a manufacturer for a specific batch of medications, staff would not be able to identify whether or not unlabelled medications were part of the batch.

- Within the plastic basket we found a medication which had been prescribed as a take home medication for a specific patient who had been discharged nearly a month prior to the inspection. When we checked this patient's records, we found they had received eight tablets and more than this number were absent from the pack. This meant the other tablets may have been administered to other patients, as there was no stock of the medication. We were also unable to ascertain if the patient in question was given a new stock of these tablets to take home.
- We also found there were two strips of tablets in the boxes of different medications. These strips of tablets had very similar labelling to the boxes of tablets. This increased the risk of an incorrect medication being administered to a patient.
- Within the medication cupboard on the ward we found six bottles of liquid medication that had been opened, but without recording the opened date. It is important that liquid medications have the date they were opened clearly documented. This is to ensure they are discarded within the manufacturer's guidelines.
- A bottle of acetone nail polish remover was found in the medication cupboard in the ward area within the liquid medication bottles area. This cupboard was a standard wooden cupboard and was not designed to contain spillages. This bottle had very similar labelling to the oral liquid medications stored with it, which posed a risk of error. If acetone was administered in error orally, this could be very harmful to a patient.
- The Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR) set out how flammable liquids should be stored. Acetone is a highly flammable liquid and in line with these guidelines should be stored within a suitable cupboard of fire resistant construction, which is designed to retain spills in a designated area. This area should be away from direct working areas to minimise the risk of fire. The storage of acetone in the manner observed on the ward therefore posed a risk to patient's safety due to the increased risk of fire. This is reiterated in the data sheet and guidance from the Control of Substances Hazardous to Health regulations (COSSH, 2002) for storing and using acetone, which states this substance should be stored in a designated paint store or equivalent and only used in a well ventilated area. All the issues relating to medication found in the ward area were immediately highlighted to the senior management team, who produced an action plan and took immediate remedial action.
- In the theatre areas we found the anaesthetic rooms did not have a lock function and were left unlocked at all times. Medications were secured in locked cupboards when there was not a patient in theatre. However, when a patient was in the theatre these cupboards and the medication fridge were left unlocked. This meant there was unsecured staff access to medications, including anaesthetic medications, insulin and powerful pain killers. Although the theatre areas did not have swipe or key pad access, they were not easily accessible to the public and the reception area was staffed during the day time. The controlled drug cupboards in the anaesthetic rooms remained locked during these times.
- We reviewed four controlled drugs record books in theatre and recovery areas. These books showed wide spread omissions and issues with the recording of controlled drugs. We reviewed 160 entries in total and found key information was missing in all 160 entries. This included times of administration, signatures for supply, administration and destruction, dosage details and documentation of amounts of controlled drugs destroyed. The entries missing were required from all staff groups including doctors, nurse and operating department practitioners.
- We reviewed a further 50 entries in the controlled drugs book for the recovery area. All 50 entries were correctly completed and signed in this book.
- We raised our concerns with theatre management, who informed us they were fully aware of widespread issues with the recording in the controlled drug books. We asked what action had been taken as a result of this and were told of two actions. These actions were that a letter had been provided to all consultants working in the hospital to remind them of the correct process and that all consultants had been provided with the controlled drugs policy. We later discovered that neither action had been undertaken and there were no plans to take these actions forward.
- The registered manager and matron provided assurance this would be immediately addressed and an action plan was provided on the last day of the inspection, which outlined key actions that would be taken.

- When we returned for the unannounced inspection we found the situation had not improved. We reviewed two controlled drugs records books and found the same widespread omissions of dates, times and drug dosages. This was despite the matron and theatre management undertaking daily audits of all controlled drug record books. We requested ten sets of patients' records to establish whether or not the drug dosage and timings were present on the patient's prescriptions charts. In all ten sets of records this information was recorded inconsistently and it was unclear as to when the drug had been administered and at what dosage.
- The hospital commissioned pharmacy provision from a neighbouring NHS trust. The hospital had an on-site pharmacy so that medicines required for patients were readily available. The pharmacy team also carried out a quarterly audit of controlled drug records books. However, the audits completed were not sufficiently detailed to highlight the concerns identified during the inspection. Theatre management told us that the audit tool in use by the pharmacy team was not sufficiently detailed to identify the issues we saw. No action had been taken to address this flaw in checking compliance.
- We saw that medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out regular reviews of stock on the ward.
- We looked at the ward based medication charts for three patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- Medical records were paper based and were securely stored behind the nurses' station.
- Records were not well managed and were not always up to date. They were poorly organised and often contained loose pages, which posed a risk that key information about patient care could be lost. Some records did not contain sufficient details about patients' care and lacked dates and times.
- We reviewed ten sets of patient records and in all ten records we found at least one section of the records had not been completed. In ten out of ten records, at least one section was not dated and timed.
- In four cases, we found the anaesthetic pre-assessment record form lacked the time and the date it was completed.
- In two cases, we found the anaesthetic pre assessment record form was either missing or blank.
- Timings relating to controlled drugs and other medication administration in theatre were poorly recorded and were unclear in all records we reviewed.
- In three records, key information relating to patients' previous medical conditions was not documented.
- Staff signatures were illegible and it was unclear in all records as to who had provided care to the patient.
- There were no record keeping audits completed.

Safeguarding

- Training rates for mandatory training in safeguarding were significantly below the hospital target of 100%.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction followed by three yearly safeguarding refresher training for safeguarding children and adults.
- Clinical staff were required to undertake level one training for safeguarding children and level two training for safeguarding vulnerable adults. Some senior staff were also required to undertake level three training. This did not meet the intercollegiate guidelines for safeguarding training, which outline that staff who have continued interaction with children or adults require level two safeguarding adults training and level three safeguarding children training. Hospital data showed that eight out of 15 staff in the theatre areas either had no record of level one safeguarding children training or were out of date with this training. This meant that only 46% of staff working in the theatre areas had up to date training in this subject.
- Only one out of 15 staff working in the theatre areas had received level two safeguarding children training. This meant that only 6% of the staff in the theatre areas had received level two training.
- Theatre management were unaware of these low rates and was unable to offer any explanation or action plan to address this issue.

- The uptake rates for this training on the ward area were higher, but still low. Seventy-eight per cent of staff had undertaken level one safeguarding children training and 35% of staff had undertaken level two training.
- The only staff to undertake level three safeguarding children training were the outpatient manager and hospital matron. There was a designated nurse for safeguarding children within the Ramsay Health Care UK group.
- In the theatre areas only 33% of staff had undertaken level one safeguarding vulnerable adult training; no staff had undertaken level two or level three training in this subject including theatre management. The uptake was slightly higher in the ward area. Fifty per cent of ward staff had undertaken level one training and 14% of staff had undertaken level two training in this subject.
- The staff in the ward area we spoke with were aware of how to identify issues of potential abuse and neglect and how to report safeguarding concerns and access support and advice. However, we asked two staff in the theatre areas about how they would identify abuse and report it and neither could tell us how they would report a safeguarding concern. They told us they would complete an incident form, but were unaware of how to access and complete a safeguarding referral form.
- Information on how to report safeguarding concerns was clearly displayed in the ward area we inspected.
- The ward manager told us there had been no reported safeguarding incidents in the last year for the ward area. Theatre management were unable to tell us whether there had been any reported for theatre areas, although we had previously been given information by the hospital that there had been one safeguarding concern reported in February 2016 in this area.

Mandatory training

- At the time of the inspection, the registered manager was unable to give us an accurate figure for mandatory training because of issues with the reporting system. This had been identified by the hospital in May 2016. However, it had not been resolved at the time of the inspection. This meant the hospital was unable to provide accurate details of how many staff had completed mandatory training modules.
- However, following the inspection the senior management team provided us with updated figures relating to training rates. This showed that uptake levels of mandatory training were significantly below the hospital target in key subject areas.
- Eighty-five per cent of staff working in the ward area had undertaken basic life support training and fire safety training. However, we found that only 57% of these staff had undertaken health and safety and infection prevention and control training. We also found that only 14% of eligible staff had undertaken immediate life support training. The hospital target for all of these subjects was 100% of eligible staff.
- Theatre management and matron told us they expected all registered nursing staff working in the theatre areas to undertake immediate life support as a minimum. Information provided by the hospital showed that 60% of staff working in the theatre areas had undertaken basic life support, but only 11% of the staff requiring immediate life support had undertaken this training. This was significantly lower than the hospital target of 100%.
- Only 60% of staff working in theatre areas had undertaken fire safety training and only 20% had undertaken health and safety training. Only 26% of staff working theatres areas had received infection control and prevention training and no staff had undertaken training in the use of medical gases.
- Theatre management were unable to tell us where they would locate information on training rates and was unaware of the training rates for staff. They were also unable to provide any assurance or evidence of action taken to address these very low compliance rates.

Assessing and responding to patient risk

- Staff were expected to carry out preoperative risk assessments prior to surgery, to identify patients at risk of harm. Patients at high risk were required to be placed on care pathways and care plans to ensure they received the right level of care. We found that these were not always completed and in most cases as least one assessment was incomplete.
- In four out of ten records, there had been no venous thromboembolism risk assessment completed, which was a requirement for every patient.
- In five out of ten records, we saw no evidence that a moving and handling assessment had been completed.

- In nine out of ten records, we found that there was either no assessment or an incomplete assessment of the risk of pressure ulcers.
- Patients were required to be assessed by an anaesthetist and surgeon on the day of surgery to identify patients with underlying medical conditions or those who were at risk of developing complications after surgery. This contributed to the decision on whether or not a patient could be operated on at the hospital. We found that anaesthetic assessments were consistently poorly documented. We reviewed ten anaesthetic assessments and found that in nine of these cases key information was missing and in two cases no information was recorded at all. In two cases, the patients' medical history was not recorded accurately. In one case we found that a patient had a history of breathing problems, which was not documented on the anaesthetic assessment. In all the assessment records there were no instructions for nursing staff in the ward area to guide the patient's pre and post-operative care.
- In theatre, we identified serious concerns about life support training. Six out of eight theatre staff files showed that staff had not completed the correct level of life support training required for their role, as set out by Ramsay Health Care UK and the association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. This included nursing staff who had not undertaken immediate life support training and one consultant who was out of date with immediate life support training. On 7 October 2016, in one theatre only one out of three staff who required immediate life support training had received this within the required timescale (two yearly). The consultant surgeon was also out of date with immediate and basic life support training, although the anaesthetist did have up-to-date advanced life support skills. This meant that staff in the theatre did not have the correct level of training to care for patients in the event of a respiratory or cardiac arrest.
- The association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines for immediate post-anaesthesia recovery (2013) state that, as a minimum, one member of staff with advanced life support skills should be present for post anaesthesia care and recovery. On 7 October 2016, there was no member of staff in the recovery area who had undertaken advanced life support training, as set out in these guidelines. This meant that staff in recovery did not have the correct level of training to care for patients in the event of a respiratory or cardiac arrest.
- We reviewed staffing lists for theatre cases due to be undertaken over a two day period and the associated training records of the staff listed. We found from the records that for six out of eight medical staff due to be either operating or providing anaesthetic care, their life support training was either out of date or not listed.
- A number of staff interviewed independently of each other told the inspection team that it was routine for anaesthetists to leave the operating theatre for periods up to 20 minutes. The reasons for these absences ranged from toilet breaks, preparing other non-urgent cases for anaesthesia, meal breaks and watching television in the break room. Fewer staff also said that at times both the anaesthetist and the anaesthetic assistant would leave the operating theatre, leaving the patient without anaesthetic support.
- The Royal College of Anaesthetists guidance on the provision of anaesthesia for intra-operative care (2014) states that "an appropriately trained and experienced anaesthetist must be present throughout the conduct of all general and regional anaesthetics and procedures requiring sedation given by an anaesthetist. In exceptional circumstances, for example where urgent treatment is required for another patient, the anaesthetist may need to delegate this care for a short period". It also states that "an anaesthetic assistant who is trained, competent and holds an appropriate recognised national qualification must be present throughout the entire anaesthetic procedure, and provide exclusive assistance to the anaesthetist". This is to ensure that any risks to patient safety during operations are minimised. Therefore this routine practice by the hospital's anaesthetist staff exposed patients to an unacceptable level of risk.
- There was no system in place to routinely check agency and bank workers' mandatory training compliance, level of life support training and competencies to work in designated roles, such as operating department practitioner (ODP) and scrub staff. The Association for Peri-operative Practice (AfPP) recommends that all staff employed in a specialist role, for example scrub or ODP, should receive adequate training and be subject to a robust competency based assessment. Theatre management were unable to locate the training and

competence records for substantive staff. This posed a risk that patients could have been cared for by staff that did not have the skills, qualifications or competencies to do so.

- Theatre staff were required to carry out 'safety huddles' on a daily basis, to ensure all staff had up-to-date information about risks and concerns. We observed that these safety huddles were only attended by one member of staff from each theatre and the information contained in these huddles was not always passed on to all staff.
- Staff raised concerns during the inspection that the World Health Organization (WHO) checklist and process was not always followed during operations. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors before, during and after surgery.
- We observed three theatre teams undertake the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- However, we found that in three out of ten patient records the WHO checklist section within the records had not been completed fully. The hospital expected this to be completed for every patient. This included the counting of the number of swabs following surgery.
- An early warning score (EWS) system was in use in all areas. The EWS system was used to monitor patients' vital signs, identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. Staff carried out monitoring in response to patients' individual needs to quickly identify any changes in their condition.
- There was a resident medical officer (RMO) on site, 24 hours a day, to respond to urgent calls and emergencies. The hospital had a transfer agreement in place so deteriorating patients could be transferred to a local acute trust if needed.
- The service undertook an audit on surgical safety in January, April and June 2016. The results of this audit indicated worsening compliance between these dates, decreasing from 93% in January 2016 to 77% in June 2016. Despite this worsening picture, there were no actions documented to address areas of concern on any of the audits and we found no evidence that any action had been taken to address the areas of concern. Areas of low compliance included the lack of staff signatures and completion of paperwork relating to the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist.

Nursing and support staffing

- We were not assured that the correct number of suitably qualified staff were always deployed in the theatre areas. There was also a high usage and reliance on bank and agency nursing staff to support the permanent staff.
- The expected staffing levels for theatre lists and areas were set out in the provider's standard operating policy for theatres. The policy was in line with guidance set out by the Association for Peri-operative Practitioners (AfPP) (2014).
- The standard requirement for each theatre list was two scrub practitioners, one circulating practitioner and one anaesthetic assistant (ODP), as a minimum for cases involving the administration of an anaesthetic and major procedures. The staffing levels for minor cases not requiring anaesthetic remained the same with the exclusion of an OPD.
- The service ran routine lists of both minor and major procedures. Staff told us and we observed that the minor cases were listed for rapid throughput. Nursing and medical staff told us it was common practice to have one patient in theatre itself and another patient waiting in the adjoining anaesthetic room at the same time and the anaesthetic staff would leave theatre to prepare this next patient for theatre.
- Three staff members told us there was a reliance on agency and bank staff who were not always regular staff with existing knowledge of the hospital or theatre. These staff also told us that theatre lists were frequently understaffed and some staff, for example health care assistants, were required to move theatres mid operation.
- Records showed the theatre department only had twelve members of staff on substantive contracts, including theatre management; all other staff were either agency staff or from the hospital bank.
- We found that there was a very high usage of bank and agency staff within the theatre areas. In April, May and June 2016, records showed the theatre areas used over 60% bank and agency staff to fill shifts. For two of these months, the usage was over 70%, with the highest being 78% usage. This meant that 78% of the staff working in the theatres areas in May 2016 were not permanent staff.

- We reviewed theatre allocation lists for a three week period. There was a high use of agency staff on all shifts in this period. In total, 57 different staff members worked within the theatre areas. When we reviewed records and spoke with agency staff, we found they were employed by five different agencies.
- Staff also told us the agency staff who worked within the department were not always competent to undertake the role they were booked for. We saw no evidence this had been escalated to theatre management.
- We reviewed five agency nursing staff files, including training and competencies records, for staff working in the theatre and recovery areas during the inspection. One out of the five staff had mandatory training which had lapsed a month prior to the inspection, one had current and up to date training and the other three staff had no records of training. This training included basic life support and safeguarding. In four records, there was no evidence of independently signed and assessed competencies, with only self-assessment of competencies present. In four records we also found there was no evidence of disclosure and barring checks and no certificate of competency in their respective speciality.
- Theatre management told us that as a minimum they would expect all agency and bank staff to possess immediate life support training. We found that in four of the five records we reviewed, there was no evidence of immediate life support training and in one of the four, the staff member's basic life support course had expired. We highlighted this to the registered manager, who subsequently made attempts to confirm the level of life support training held for staff in theatres for the days immediately following our inspection.
- We reviewed three weeks of theatre allocation sheets and theatre case lists. On 16 out of 49 occasions during this period, major case lists were short by one member of staff. Due to a lack of role allocation on the lists and staff having dual roles, we were unable to ascertain the designation, which was lacking. All the cases which lacked one member of staff were major procedures including cosmetic surgery and joint replacements requiring general anaesthetic.
- In the same period we found that two theatre lists, including patients undergoing a general anaesthetic, were short by two staff members.
- In a further two minor operation lists requiring local anaesthetic, there was only one staff member present and in one case this staff member was a health care support worker.
- Sickness rates varied between areas and months. The rates of staff sickness in the theatre areas showed a reduction for the three month period April to June 2016. In June 2016 the sickness rate had reduced to 1.7% in the theatre areas. Staff sickness rates for the inpatient ward were consistently low for the same three month period, with the overall sickness rate being 1.8% in June 2016.
- Records showed that staff turnover rates were very high for both the theatre and ward areas. In the theatre areas the turnover rate for the period June 2015 to June 2016 was 100%. This means that 100% of staff employed in the theatre areas left and were replaced during this time. The turnover rate for the same period for the inpatient ward was 78%. This means that 78% of staff employed in the inpatient ward left and were replaced during this time.
- The ward area had a sufficient number of trained nursing and support staff with an appropriate skills mix to ensure that patients received the right level of care. However, records showed that the ward had a high usage of bank and agency staff at 41% over the twelve month period between June 2015 and June 2016.
- The matron and theatre management told us the staffing establishment was set in advance, based on planned procedures and patient acuity. They told us staffing levels were increased if a patient requiring additional support was identified during their pre-operative assessment.

Medical staffing

- Medical cover on the ward was provided by a resident medical officer (RMO). During their shift, the RMO was based at the hospital 24 hours per day. The RMO was on duty between 7.30am and 10pm daily and was on-call during out-of-hours periods.
- Ward staff told us the RMO cover was sufficient to meet patient needs, because the majority of patients were assessed as low risk and did not have complex medical needs.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists, who were mainly employed in substantive posts by other organisations (usually in the NHS) and had practising

privileges (the right to practice in a hospital). Medical staff were required to provide proof they had undertaken operations elsewhere in the same clinical field.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay. Patient records showed consultant reviews were carried out on a daily basis.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed, including out-of-hours. Arrangements were in place for consultant cover during periods of sickness or leave.

Emergency awareness and training

- The hospital had a business continuity plan that listed key risks which could affect the provision of care and treatment. Staff were aware of how to access this information when needed.
- The ward and theatre staff had written guidelines to follow in the event of a major incident, such as a fire or power failure.
- However, staff we spoke with were unable to articulate what they would do in the event of a major incident and told us that they did not receive training in this subject.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- Patients received care according to national guidelines from organisations, such as the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines.
- Staff in the ward and theatres used enhanced care and recovery pathways, in line with national guidance.
- Staff used integrated care pathways for surgical procedures, such as for hip or knee replacement and these were based on national guidelines.
- Staff we spoke with told us policies and procedures reflected current guidelines and were easily accessible via the hospital's intranet.
- Patients were not always assessed for their risk of developing a venous thromboembolism (blood clot) on admission. However, when this had been completed, we saw evidence that patients were given treatment in line with NICE quality statement (QS) 66. Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50).

Pain relief

- Staff assessed patients pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- Patient records we reviewed showed that staff gave patients appropriate pain relief when required. This was confirmed by the patients we spoke with.

Nutrition and hydration

- The hospital's guidelines for fasting before surgery (the time period where a patient should not eat or drink) were clear and reflected national and current guidance
- There was no clear system in place to identify patients in need of assistance with eating and drinking. However, we found that most patients had low dependency needs and did not require assistance with eating and drinking.
- The patient led assessment of the care environment (PLACE) between February 2016 and June 2016 showed that the hospital scored 72% for food, which was lower (worse) than the England average of 91%.
- Patients told us staff offered them a variety of food and drink and did not tell us of any concerns about the food and drink provided.
- Meals for patients with dietary requirements were readily available including halal, low sugar, low fat and gluten free options.

Patient outcomes

- Managers told us the hospital participated in the national audit program patient reported outcomes measures (PROMs).
- Patient reported outcomes measures (PROMs) data between April 2014 and March 2015 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement procedures was either better than, or similar to the England average for both knee and hip replacement surgeries.
- There had been 17 unplanned patient readmissions to the hospital within 28 days of discharge between April

2014 and March 2015. The rate of unplanned readmissions was similar to what would be expected during this period when compared to other independent acute hospitals.

- The number of unplanned patient transfers to another hospital between July 2015 and June 2016 was higher when compared to the other independent acute hospitals. There had been 17 transfers of surgical patients to other hospitals during this period. During this same period, there were eight patients who had an unplanned return to theatre. Each of these cases was looked into by the hospital management team and actions identified for improvement where appropriate.
- The hospital was part of the Ramsay Health Care UK group and as such participated in the corporate audit program. This program was comprehensive and set out key audit dates and re-audit periods for specific areas, including safe surgery, consent, nutrition and infection prevention and control.
- An audit was undertaken on an annual basis, assessing how effective patient's peri-operative care was. The audit included whether or not specific equipment was available, if the correct staff were present during surgery and the availability of call bells. This audit was last undertaken in December 2015 and the service scored 94% overall. However, there were a number of areas in which the service scored 0% compliance; these included the availability of tilting beds, handover information and records of qualifications of staff working in the recovery area. Actions were highlighted as a result of the audit, however, there were no actions outlined or in place to address the unavailability of training records for staff working in the recovery area. This audit was undertaken again in April 2016 and showed some areas of non-compliance remained, with additional areas of concern, including drugs being left unsupervised.
- A separate audit was undertaken in April 2016, which assessed the quality of anaesthetic care provided to patients. The service scored 90% overall in this audit. There were a number of areas highlighted for concern, including the documentation of patient vital signs, weight, height, present medication and allergies. There was an action listed for this to be discussed by theatre management in a medical advisory committee. We were unable to find any evidence to indicate this had been undertaken or addressed and there was no re-audit of these areas of concern.
- The service undertook an audit to measure the quality of care patients received in relation to peripheral venous cannulas in December 2015. This showed that the service was 85% compliant with the standards of measurement at this time. These standards included documentation of the reason for insertion, management of the cannula and removal of the cannula. The areas highlighted for concern related to the documentation of insertion date, reason and device number. Actions were identified for action and we saw evidence that these had been undertaken.

Competent staff

- Newly appointed substantive staff underwent an induction process and their competency was assessed prior to working unsupervised.
- The matron reviewed staff records routinely to ensure nursing staff had current professional registration. The computer system used to store this data alerted the senior management team when nursing staff professional registrations were due to lapse.
- Staff on the inpatient ward told us they received annual appraisals. Staff in the theatre areas told us they did not always receive an annual appraisal. Records showed that 67% of inpatient ward nurses, 0% of healthcare assistants and 77% of other professionals working on the ward had completed their annual appraisals between April 2015 and April 2016.
- Records showed that 43% of theatre nurses and 25% of healthcare assistants and operating department practitioners had completed their annual appraisals between April2015 and April 2016.
- Theatre management told us they did not routinely request the competency or experience records for new agency staff working in the operating theatres and recovery area. They also told us they relied entirely on the third party agency for assurance on training and competency of agency staff members.
- All consultant surgeons and anaesthetists were required to maintain current practicing privileges in line with the providers practicing privileges policy. Each individual consultant was responsible for keeping their information up-to-date and current.
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC). This included a review of appraisals, General Medical Council (GMC) registrations and medical indemnity insurance.

- We spoke with consultants, who told us they underwent peer appraisal and revalidation at their NHS acute trust. This information was provided to the hospital to ensure it held up-to-date records about the consultant.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers.
- Staff working on the inpatient ward had up-to-date personnel files, which were maintained and reviewed by the ward manager. These files included set competencies for their roles.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the ward and theatre areas. Staff told us they had a good relationship with consultants and the resident medical officer (RMO).
- Patient records showed there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.
- There was evidence of daily communication between the pre-operative assessment staff and ward and theatre staff to ensure patient care could be coordinated and delivered effectively.

Seven-day services

- Routine surgery was performed in the theatres during weekdays and on Saturdays.
- The inpatient ward accommodated overnight patients seven days a week and staffing levels were maintained during out-of-hours and weekends.
- The RMO provided out-of-hours medical cover for the inpatient ward 24 hours a day, seven days per week.
- Patients were seen daily by their consultant, including on weekends.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed. They told us they did not experience any difficulties in accessing consultant support outside normal working hours.
- The imaging department had an on-call radiographer available 24 hours a day, seven days a week for X-ray.

Access to information

- Staff could access information such as policies and procedures from the hospital's computers.
- Medical staff produced discharge summaries from the electronic patient system and sent them to the patient's general practitioner (GP) in a timely way.
- This meant the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might need. Staff provided patients with copies of their discharge summaries.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to explain how they obtained consent from patients or their representatives and were clear on how to seek verbal informed consent and written consent before providing care or treatment. An internal audit undertaken in June 2016 showed that the service scored 100% compliance in relation to consent processes. However, the training uptake rate for informed consent training required for all surgical services staff was 0%.
- The consultants obtained consent from patients undergoing surgery during the initial consultation and again on the day of surgery. Patient records showed that consent had been obtained from patients or their representatives and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out a surgical procedure.
- Staff were not aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS). Training on these subjects was delivered as part of the level two adult safeguarding course. No staff in theatre and only 14% of staff on the ward had attended this training.
- Staff told us that patients admitted to the hospital usually had the capacity to make their own decisions. Where patients lacked the capacity to make their own decisions, staff told us they would seek advice from senior staff.
- There was a Ramsay Health Care UK do not attempt cardiorespiratory resuscitation policy in place. This was supported by an advanced directive policy. Advanced directives are legally binding declarations to refuse medical intervention or procedures in certain circumstances.

Are surgery services caring?

Inadequate

Surgery

Good

We rated caring as good.

Compassionate care

- We observed staff treating patients with kindness, respect and compassion. Staff took time to interact with patients and communicated with patients in a considerate and compassionate manner.
- Patients' dignity was respected. We observed that doors were closed and curtains drawn when staff were providing personal care.
- We spoke with seven patients, who all gave us positive feedback about how staff treated and interacted with them.
- The service undertook an internal Friends and Family Test (NHS FFT), which was a satisfaction survey that measured patients' satisfaction with the healthcare they have received. The results showed that between February and June 2016, 100% of patients were satisfied with the care they received on the inpatient ward, although only 1% of patients responded to this test.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and communicated with patients in a way they could understand.
- Patients told us staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and about the quality and content of written materials, such as information leaflets specific to their condition and treatment.
- Patients told us medical staff fully explained the treatment options to them, including risks and benefits, so they were able to make informed decisions.
- Staff identified when patients required additional support in their care and treatment, including translation services for patients whose first language was not English. Staff were able to tell us how they would access translation services, including sign language interpreters for patients with hearing difficulties.
- Pre-operative assessments took into account individual preferences.

Emotional support

- Staff demonstrated that they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives when they were feeling anxious.
- Patients told us staff supported them with their emotional needs.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of local people

- Patients had an initial consultation to determine whether or not they needed surgery, followed by a pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance, so they did not experience delays in their treatment when admitted to the hospital.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the hospital, using the American Society of Anaesthesiologists (ASA) physical status score. The majority of patients admitted to the hospital had an ASA score of 1 or 2, which meant that patients were generally healthy or had simple pre-existing health conditions. Patients with complex pre-existing medical conditions were excluded from being treated at the hospital and were referred for their care elsewhere. Patients were informed during the pre-assessment if they were able to have treatment at the hospital. GPs and doctors at NHS trusts were made aware of the admission and exclusion criteria for patients to be treated at the hospital. Additional screening was undertaken by consultants working at the hospital when referrals were received.
- The ward was open 24 hours a day, seven days a week and had 17 overnight beds and eight day case beds.

Access and flow

Inadequate

Surgery

- There were 925 overnight patients and 4424 day case patients admitted to the hospital between June 2015 and June 2016.
- Patient flow was managed by daily communication between the pre-operative assessment staff and ward and theatre staff.
- Discharge planning was started during pre-assessment to determine how many days patients would need on the ward. This included ascertaining whether or not patients were likely to require additional support at home when they were discharged.
- Patient records showed staff did not always fully complete the discharge checklist that covered areas such as medication and communication to the patient and other healthcare professionals (such as GPs) to ensure patients were discharged in a planned and organised manner. However, we did not identify any impact relating to the admission or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- The hospital met the indicator of 90% of admitted NHS patients beginning treatment within 18 weeks of referral for each month between June 2015 and June 2016.
- Records showed there had been 152 operations cancelled for non-clinical reasons between June 2015 and June 2016. This accounted for 2.8% of the total surgical activity for this period. Records showed that 100% of these cases were rebooked within 28 days of the patient's original surgery.
- Admissions for patients undergoing day case procedures were staggered to minimise waiting times.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.
- Staff could access a language interpreter if needed.
- Staff were aware of when they needed to make reasonable adjustments for patients living with a disability. However, there were no specific arrangements to make adjustments or considerations for patients living with a learning disability or dementia.
- The hospital PLACE score for the environment for patients with a disability was 77%, which was lower than the England average of 81%.
- Staff received mandatory training in equality and diversity. Records showed 65% of staff across the service had completed this training. This was below the hospital target of 100%.
- The hospital did not carry out any invasive surgical procedures on patients under 16 years of age. Young people aged 16 years and above could be admitted for day surgery. Surgery was only performed following the completion of a formal risk assessment as part of the pre-assessment process.
- Records showed that between June 2015 and June 2016, there were 17 day surgery patients in the 16 to 17 year old age group that were treated at the hospital.
- The hospital had a dementia strategy, however, staff working on the ward and in theatres were unaware of this strategy.
- Two staff in theatre and nine staff on the inpatient ward had completed dementia training. This meant that only 32.3% of staff had received training to enable them to meet the individual needs of patients living with dementia.

Learning from complaints and concerns

- The hospital had a complaints policy and aimed to acknowledge all complaints within 24 hours and to provide a full response within 20 working days. From information provided by the hospital, most complaints met these timescales. We reviewed seven complaints and saw they were all acknowledged within 24 hours. The complaints were responded to quickly, with the majority responded to before the 20 working day period. The response to one of these complaints had taken 22 days, although we saw that the complainant was informed of the delay and the reason for this
- The hospital's response to complaints was defensive in nature in some cases; this resulted in further correspondence from some complainants. One complainant said they felt they had been accused of lying in the response letter. A meeting was then held where the complainant did feel heard and was satisfied with the local resolution. The senior management team acknowledged this was an area of improvement, which they were already working on. Part of the improvement work in this area was to encourage staff to resolve concerns as they arose with patients, rather than telling them to put their complaint in writing, which had been normal practice at the hospital.

- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas.
- The local ward and theatre management and matron were responsible for investigating complaints in their areas.
- We saw evidence of learning from complaints and this learning was disseminated through staff meetings and written communications.
- Staff were able to describe improvements made following complaints and we saw evidence that themes were identified, discussed and acted upon. We were given the example the poor patient experience provided through the day case pathway. The hospital changed the pathway and had seen a reduction in complaints in this area since doing so.

Are surgery services well-led?

Inadequate

We rated well-led as inadequate.

Vision and strategy for this this core service

- There was a corporate strategy and vision called the 'Ramsay Way'. This strategy and vision set out the behaviours and values expected of staff working for the organisation.
- There was also a local corporate strategy, which was called the Northern Blitz Spirit. This involved hospitals within the northern regional team working together to determine subjects or areas to tackle over the period of the year.
- Staff we spoke with were unaware of both the Ramsay Way and the Northern Blitz Spirit. They told us they were unaware of any local strategy within the service. The hospital did not use value-based recruitment or reflect Ramsay Health Care UK values within the appraisal process. Values-based recruitment is a way of recruiting staff whose values and behaviours match those of the hospital.
- There was no clear strategic direction in place. The hospital provided us with a draft clinical strategy. This was a basic document relating to CQC's five key questions and did not describe what the hospital's strategic clinical aims for the future were.
- There was no credible strategy for the surgical services and managers told us they followed the corporate strategies.

Governance, risk management and quality measurement

- There was a Ramsay Health Care UK wide risk management policy in place. This set out the responsibilities of managers and senior managements in relation to risk management.
- Risk management was not understood or practiced effectively within the service. Staff, including senior staff, were unaware of risk registers or how to escalate a risk to the risk register. There was a hospital wide risk register in place that could be accessed only by the senior management team. A total of 20 risks were identified on the register, with only three open risks that related to clinical care. The remaining risks were related to finances or facilities. Risks on the register were not appropriately rated using the rating system set out in the risk management policy. There was insufficient monitoring and review of risks detailed on the risk register. There was an action plan in place alongside the risk register to reduce agency staff usage in theatres, but not all actions within this action strategy document had a date for completion. None had a status update in the status column.
- The continued poor compliance in relation to controlled drugs was a further example of a failure to use the systems and processes in place to monitor and mitigate risks. This widespread issue was not detailed on the risk register as part of the identified risk of failure to comply with home office licensing requirements. This was despite the fact that theatre management told inspectors they were fully aware of serious and significant issues in relation to the documentation and management of controlled drugs in theatres.
- A number of risks we expected to see on the risk register, based on the findings of our inspection, were not on the risk register. These included issues relating to the monitoring of training via the electronic training system, staff morale and issues concerning damage to theatre equipment (such as holes in tray wraps and damage to trays), which had led to the cancellations of operations in May 2016. We were provided with evidence during the inspection that actions had been taken to address the risks in relation to theatre equipment. However, these

issues had not been assessed, monitored or managed within an effective risk management framework, as set out in the Ramsay Health Care UK risk management policy.

- A new electronic system had been implemented in May 2016 to monitor compliance with training. The registered manager told us compliance monitoring of mandatory training using this system was not possible, as e-learning modules did not update the "master tracker". This meant the hospital could not provide us with up-to-date training figures in relation to essential training, because these figures were not available. This training included all levels of life support training, safeguarding children and adults training, manual handling training and infection prevention and control training. This issue had been ongoing since May 2016.
- There was no evidence in the minutes of heads of department meetings that any action had been taken to provide assurance that essential training was up to date throughout the hospital during the six month period from May 2016 to October 2016.
- Minutes of the clinical governance committee meeting, dated 13 May 2016, stated that heads of departments were responsible for managing mandatory training in departments. There was no interim system or method put in place to enable heads of departments to monitor this. There was no evidence of discussion of compliance with mandatory training under the agenda item "training" during clinical governance meetings between May and August 2016, or at heads of department meetings in May, June or July 2016.
- There was limited evidence of discussion or review of risks on the register in the heads of department and clinical governance minutes we reviewed. For example, in March 2016, the minutes of the clinical governance meeting solely stated: "All to review for own departments and report at next meeting". At the subsequent meeting in May 2016, the minutes stated: "still to complete for theatre".
- In August 2016, the entry under the risk register states: "each department has now transferred risks onto new risk register forms onto g-drive with appropriate action plans. [Initials removed] has updated Hospital risk register for use of agency". The new risk register forms referred to in this meeting were risk assessment forms and were not part of the risk register. This demonstrated a lack of understanding of the difference between risk assessments and a risk register and the associated risk management strategies on the part of the senior management team.
- We also noted that a staff member who had been assigned the action to review the risk register was an assistant theatre practitioner and therefore was not responsible for undertaking this task. As per the Ramsay Health Care UK risk management policy, this should have been undertaken by the registered manager.
- There was a clear corporate governance structure in place with committees, such as infection control and health and safety feeding into the clinical governance committee and medical advisory committee (MAC). However, senior managers within the service were unable to tell us how they reviewed and brought together different streams of governance to inform risk management, such as internal incident review, thematic review of complaints data and review of incident data.
- Clinical governance meetings were held monthly. There was an action tracker attached to the minutes of clinical governance meetings with lead staff and timescales for action identified. Similarly, actions from minutes of the lessons learnt forum (a key part of the hospital's system to learn from incidents, complaints and concerns) were not carried forward correctly or had no date for completion. On 28 July 2016, one action states: "arrange endoscopy meeting", with the date column stating: "This has carried forward for the last few meetings. Please address ASAP". On 30 August 2016, this action had still not been undertaken and by September 2016, this action was no longer listed or referenced during the minutes.
- The minutes from the Medical Advisory Committee (MAC) meeting were very brief and did not provide a robust audit trail of any challenge, discussion or outcomes. The Chair of the MAC had been undertaking this role for around 15 years.
- There were robust processes in place for granting and reviewing practising privileges. However, the 'Facility Rules' document outlining these, had not been reviewed since it was introduced in November 2011. Likewise, the terms of reference for the MAC were from 2013, with no evidence of review.
- We reviewed minutes from the theatre departmental meeting. The issue regarding the controlled drugs books had been highlighted at this meeting in May and June 2016, but had not been fed into any other meeting. The

registered manager and matron did not have sight of these minutes. In the July meeting, the issue was highlighted again and a comment that 'results were looking good' was entered by the minute taker. We found that no auditing had been undertaken to monitor this and there was no evidence that the situation had improved. We found no action had been taken to address this issue.

- The same issue had been highlighted during a corporate provider visit and a subsequent action plan had been developed in July 2016. This action plan did not contain any measurable actions and simply listed the issue. This action was closed in August 2016 and marked as completed. The senior management team could not tell us what action had been taken, or were unable to provide evidence of any action taken.
- We found that a number of audits which showed concerning low rates of compliance in areas related to patient safety, were not actioned or followed up. An example of this was the peri-operative care audit undertaken in December 2015. This audit showed there were a number of areas in which the service scored 0% compliance, including records of qualifications of staff working in the recovery area. Actions were highlighted as a result of the audit, however, there was no action planned or taken to address this. This audit was undertaken again in April 2016, but this area remained 0% compliant. Again no action was taken and the problem persisted. This was evidenced during the inspection; the senior management team were unable to provide accurate training records for staff working in this area.
- Another example of this was an audit undertaken in April 2016, which assessed the quality of anaesthetic care provided to patients. A number of concerns were highlighted, including the documentation of key information not being recorded in patient's pre-operative anaesthetic records. There was an action assigned for this to be discussed at the medical advisory committee. We found no evidence this action was undertaken or that any action had been taken to address this issue. During the inspection we found that anaesthetic charts still consistently lacked important information.
- There were poor systems in place to ensure that issues identified in the theatre area were escalated to the senior management team. An example of this was a number of issues highlighted in the theatre departmental minutes, which the matron and registered manager were unaware of. Some of these issues were listed over a number of monthly meetings. The registered manager told us they did not routinely see these minutes. Therefore there were no effective governance structures and channels to ensure that key issues highlighted in the department were raised with senior managers.
- Following the announced inspection, the senior management team put a daily audit in place to ensure compliance with guidelines and policies on the documentation of controlled drugs. When we returned for the unannounced inspection, the registered manager and matron told us this audit had shown 100% compliance. We reviewed the audit results with the controlled drug record books and found that the results did not reflect the information in the books. For example, on one date the responsible manager had signed that there was 100% compliance with all sections of the controlled drugs record book. When we reviewed the books, we found that multiple entries lacked information, signatures and times.
- The ward manager was aware of how to identify risks and gave us examples of how they would raise issues with the matron and registered manager.

Leadership / culture of service related to this core service

- The overall lead for the surgical services at the hospital, was the matron and the registered manager.
- The surgical ward was led by a ward manager. Theatre management was responsible for the day-to-day management of the theatres and recovery area.
- The permanent theatre staff spoke positively about theatre management. They told us theatre management had shown good leadership and had made positive improvements in planning and organisation within the theatres. However, some temporary staff raised concerns with us about the leadership in the theatre area.
- Some staff in the theatre areas told us they were fearful of losing their jobs. When staff told us about their concerns, they were visibly distressed and concerned about the repercussions this may have on them.
- Three staff in the theatre areas told us they felt there was a strong blame culture within the hospital. Two staff in the theatre areas told us they had felt bullied and intimidated by managers and other staff.

- This was further corroborated by the Ramsay Health Care UK staff survey, which showed that only 63% of staff working at the hospital indicated they would be happy to challenge unsafe behaviours. Fifty-four per cent of staff indicated they would feel comfortable communicating upwards and 44% of staff said they had been subject to unacceptable behaviours, such as bullying and harassment.
- The staff survey showed that a large proportion of staff working at the hospital felt they did not receive enough support from their seniors, with only 57% of staff agreeing that their line manager gave them support. The survey also showed that only 41% of staff felt the senior management team modelled the Ramsay Health Care UK values and behaviours.
- The Matron and General Manager told us that the timing of the survey might have impacted on the results, in terms of a pay review and refurbishment work. It was acknowledged that the results were worrying. We were told that a corporate team from Ramsay Health Care UK visited the hospital and supported the management team in understanding the issues raised and how to respond to them. There was an action plan in place, with evidence of actions taken. However, some areas of the survey such as staff not feeling comfortable to challenge unsafe behaviours, were not understood or acknowledged in the action plan.
- Managers were aware of a number of risks and had not acted on these risks in an appropriate way. An example of this was in relation to the documentation of controlled drugs. One manager told us they were fully aware of serious issues relating to the documentation of controlled drugs and told us of two actions that they had completed; we found that they had not. This had not been escalated to the matron or registered manager.
- Theatre management were unaware of staff's basic competence and skill set. They were unable to tell us where to locate staff files and had delegated this task to an assistant practitioner. As a result, they had no knowledge at all in relation to staff training records or mandatory training compliance.
- The minutes from the theatre departmental meetings were poorly completed, with multiple errors and did not follow the expected set agenda used by the corporate organisation or hospital.
- Staff on the inpatient ward spoke positively about the ward manager and matron and told us that they were visible and available.
- Staff in the theatre areas told us the matron was a visible presence and was actively involved in the day to day running of the theatre areas.
- Staff working on the inpatient ward told us they would be happy to raise a concern with their line manager. However, some staff in the theatre areas, including agency staff, told us they would not feel comfortable raising concerns. They told us they would be scared of not getting work at the hospital again if they raised concerns.

Public and staff engagement

- The hospital sought to obtain patient views and experience, however, this had been a challenge, with only 1% of patients responding to the friends and family test. The Matron had started monitoring this and encouraged competition between departments to improve feedback levels. Action plans were in place to respond to any negative feedback received.
- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
- The surgical services participated in the friends and family test, which gives people the opportunity to provide feedback about care and treatment they received.
- Staff meetings were scheduled for both the ward and theatre areas. These meetings were poorly attended and we found no evidence that the minutes were disseminated to staff who were not present.
- There was a corporate staff survey undertaken this year. This survey showed that Oaklands hospital had an overall engagement score of 60%. This was 11% lower than the average engagement score for the Ramsay Health Care UK group.
- In this survey, only 52% of staff felt the hospital engaged externally with patients and only 61% of staff agreed that they were informed of the direction the hospital and Ramsay Health Care UK were moving towards.

Innovation, improvement and sustainability

- We did not identify any particular areas of innovation within surgical services.

Requires improvement

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

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

We rated safe as requires improvement.

Incidents

- The hospital used a Ramsay Health Care UK group-wide incident reporting policy. Incidents were recorded using a computer based incident reporting system. The hospital reported 65 clinical and no non-clinical incidents in the outpatient and diagnostic imaging departments between July 2015 and June 2016.
- Staff we spoke with in all departments could describe the process of reporting incidents and told us they knew how to use the computer based system. Staff told us that if they reported an incident, they would also let their manager know.
- Staff told us that learning from incidents was discussed at the hospital's monthly lessons learned meeting and at departmental meetings. Lessons learned meetings were attended by representatives from each of the departments. Staff in the departments said they had attended the meeting as a representative of the department. We reviewed minutes of the last departmental team meetings and July, August and September 2016 lessons learned meetings and saw evidence that incidents had been discussed.
- Staff in all departments gave us examples of incidents reported in their departments and the lessons learned meetings and actions taken as a result of the incidents.
- In addition to the lessons learned meeting, we saw evidence of discussion of incident trends and specific incidents in the minutes of medical advisory committee (MAC) and head of department meetings, where we saw that incidents were reviewed in detail. We reviewed the incidents between March and August 2016 and found that they reflected the types and severity of incidents staff discussed with us during the inspection.
- The duty of candour is a regulatory duty relating 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. There had been one incident in the diagnostic imaging department in the year before the inspection which had triggered the duty of candour regulation. During the inspection we reviewed the investigation and saw evidence that the patient was notified of the incident, provided with support and a formal apology, in line with the regulation.
- Staff we spoke with understood the duty of candour and had a good understanding of the principles of being open and honest with patients.

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean and tidy. In the diagnostic imaging and outpatient departments, cleaning schedules were completed daily for each of the clinical rooms. While we found that the cleaning

schedules had been completed in all of the clinical rooms, the clean utility room cleaning schedule was not completed on the days that the department had been open in September 2016. While the room was clean during the inspection, because the rota was not completed every day, we could not be assured that the room had always been cleaned.

- The hospital used a Ramsay Health Care UK group-wide policy, which set out the standard precautions to be taken by staff to prevent the spread of infections. We reviewed the policy, which set out guidance on hand hygiene, use of personal protective equipment and safe disposal of clinical waste and sharps.
- All staff were expected to complete a module in infection control each year, as part of their mandatory training programme. At the time of the inspection 50% of staff in the outpatient department, 100% of staff in the diagnostic imaging department and 66.6% of physiotherapy department had completed the training.
- Between July 2015 and June 2016, the hospital carried out three hand hygiene audits and four infection prevention and control audits of the environment. In the same period, the radiology department also carried out two of its own hand hygiene audits and an infection prevention and control audit of the environment. Compliance with the audits was high, and where there was non-compliance actions were taken. The use of audits provided the hospital with assurance about the infection prevention and control practice across the hospital.
- There were bins for clinical waste, non-clinical waste and sharps in the clinical rooms. However, not all waste in the outpatient department was properly stored, managed and disposed of. In the clean utility room we saw a sharps bin which was being used for the disposal of contraceptive coils. This type of waste should have been stored in appropriate bags in a room designed to store clinical waste. During the inspection we also found the sluice room was unlocked. This should be locked to prevent patients or members of the public from entering the room.
- One of the consultation rooms in the outpatient department had a carpeted floor. Staff told us the room was not used for any invasive procedures or tests and the hospital had plans to remove the carpet.
- 'I am clean' stickers were used to show that a piece of equipment had been cleaned ready for use.
- Hand sanitisers were widely available throughout the outpatient, physiotherapy and diagnostic imaging departments. Instructions on hand washing were displayed at sinks in all clinic rooms. We saw staff using hand sanitisers in the outpatient department.
- Personal protective equipment, such as disposable gloves and aprons, were available in all the clinical rooms in the outpatient department to prevent spread of infections.
- We observed that all clinical staff in the departments followed the 'arms bare below the elbow' guidance to allow thorough hand washing and reduce the risk of cross infection.
- The hospital had a schedule to replace all curtains in clinical areas every six months. All of the curtains we saw had been changed within the last six months. This meant the risk of cross infection was reduced.
- Patient-led assessment of the care environment (PLACE) is a measure of the care environment in hospitals which provide NHS care. The assessments see local people visit the hospital and look at different aspects of the care environment. The hospital scored 100% in the PLACE for cleanliness between February and June 2016. This was higher than the England average of 98% for independent hospitals.

Environment and equipment

- Resuscitation equipment for adults and children was available in all departments. Staff had completed daily and weekly checks of the equipment. However, we found that in the paediatric resuscitation trolley the scissors, stored in a sterilised packet, had passed the manufacturer's use by date of August 2016. This meant there was a risk that the scissors were no longer sterile. We raised this with staff during the inspection, who replaced the scissors.
- The paediatric resuscitation trolley was locked and opened using a four digit code that was stored in a folder on the trolley. This meant there was a risk the trolley could be opened and the contents tampered with and staff would be unaware.
- The departments had arrangements in place for the maintenance and testing of equipment. All of the equipment we saw in the outpatient department had been tested and calibrated and a sticker added with the next testing date. The diagnostic imaging and physiotherapy departments had contracts in place for

the testing of its imaging equipment. During the inspection we reviewed folders containing the maintenance schedule and faults record, which were up to date.

- The diagnostic imaging department had a quality assurance programme in place for testing the equipment in the department. We saw results of the quality assurance stored in a folder in the department, demonstrating that the equipment was effective for its intended use.
- Appropriate personal protective equipment (PPE) was available for staff and patients in the diagnostic imaging department. The department had lead coats and gonad shields, which were checked yearly to ensure the integrity of the protective materials. This reduced the risk to patients and staff from exposure to radiation.
- The X-ray rooms had dose meters to measure the level of radiation. These readings were available for review by the radiation protection adviser.
- We saw signs outside the areas where radiological exposures were taking place in line with Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000. This ensured visitors or staff could not accidentally enter a controlled area.
- We saw signs on the doors of all the rooms in the imaging department warning female patients of the risks of being exposed to radiation if they were pregnant or might be pregnant.
- The hospital scored 94% for the patient-led assessments of the care environment (PLACE) of condition, appearance and maintenance between February and June 2016. This was higher than the England average for independent hospitals of 93%. The hospital scored 90% for privacy, dignity and wellbeing between February and June 2016. This was higher than the England average for independent hospitals of 83%.

Medicines

- Medicines in the outpatient department were stored in locked, secure cabinets in the minor procedures room. Access to medicines was restricted to authorised staff only. The keys were held by one of the nurses on duty and we saw a record of the key holder was kept in the nurses' room. We reviewed a sample of ten medicines in the outpatient department, which were all within the manufacturer's use by date.
- Medicines which were required to be stored at a lower temperature, were stored in a locked fridge in the minor procedures rooms. The temperature of the fridge and the ambient temperature of the room was checked and recorded daily, which meant the service could be assured that the drugs were stored at the correct temperature and were effective when they were used.
- Medicines in the diagnostic imaging department were stored in a locked cabinet in the department. The key to the cabinet was stored in a locked cupboard in a locked room. We saw that drugs were stock checked and the cupboard cleaned monthly. We checked a sample of drugs, which were all with their expiry date.
- In the diagnostic imaging department two cases holding emergency drugs were stored, one of which was used on the mobile MRI or CT scanner when it was visiting the hospital. The drugs were checked and restocked by the imaging department. The cases were not locked and did not have tamper seals on them. This posed a risk that drugs could be removed and that kits may be incomplete when they were needed.
- Consultants in the outpatient department provided prescriptions to patients. We saw that the prescription pad was stored in a locked cabinet in the nurses' office. Prescription sheets were numbered so a record of prescriptions made could be kept.

Records

- We reviewed 13 sets of the hospital medical record for patients who had had procedures or appointments in the outpatient and diagnostic imaging departments. The records were complete, legible and signed.
- Medical records in the outpatient department were appropriately stored within lockable cabinets in the nurses' room, which was kept locked when it was not in use. The diagnostic imaging department used an electronic system to store records including images taken.
- Records of images taken in the diagnostic imaging department were stored electronically on a picture archiving and communication system (PACS). Information about imaging requests which had taken or were taking place were stored on a separate electronic reporting information system (RIS).
- Staff told us that all NHS patients had a full medical record. Consultants offering private consultations were responsible for creating and maintaining their own records of private consultations, which they would bring

to an appointment. Staff told us that if a private patient underwent surgery at the hospital, notes from private appointments would be added to their hospital medical record, so it was complete.

- The hospital reported that within a three month period before the inspection, there were no patients seen without all relevant medical records being available. The hospital told us that if a patient attended and the record was not available, a temporary medical record would be created. Previous hospital correspondence that had been saved electronically would be printed out and added to the temporary medical record to reduce any risk to the patient.

Safeguarding

- The hospital used Ramsay Health Care UK group-wide policies for the safeguarding of vulnerable adults and children. We reviewed the policy, which outlined the types of abuse and what staff should do if they had concerns about the safety and welfare of patients. In the outpatient department, a flowchart was displayed in the nurses' office and we saw a file with key information for staff to refer to.
- The hospital training schedule stated all staff in the outpatient department, radiographers and physiotherapists, were required to complete level two safeguarding adults training. Information provided by the hospital showed 100% of outpatient staff had completed level two safeguarding adults training, but only 50% of radiographers and none of the physiotherapy staff had completed level two safeguarding adults training. This was not in line with intercollegiate guidance, which says that all clinical staff must have level two safeguarding adults training.
- The hospital training schedule stated that all staff in the outpatient department, radiographers and physiotherapists were required to complete level two safeguarding children training. Information provided by the hospital showed only 50% of outpatient staff had completed level two safeguarding children training while 100% of radiographers and physiotherapy staff had completed level two safeguarding children training. As children were seen in the outpatient department intercollegiate guidance says all staff must have level two safeguarding children training.
- The outpatient manager and hospital matron had completed level three safeguarding children training and there was a designated nurse for safeguarding children within the Ramsay Health Care UK group.
- Staff we with spoke in all departments had a good understanding of what should be reported as a safeguarding concern. Staff knew who the safeguarding leads were in the hospital and said they would raise a concern with them and also with their manager. Staff in the outpatient department gave us examples of safeguarding concerns they had escalated to the safeguarding lead, where they had been concerned about the welfare of someone visiting the hospital.
- Staff in the diagnostic imaging department told us that requests for CT and MRI scans (which were carried out by another provider, which we did not inspect) were vetted by a radiologist after the booking had been made. This was not in line with guidance, which said that all non-emergency requests should undergo a process of vetting by a radiologist or by agreed delegation to a radiographer or sonographer prior to an appointment being made. This meant there was a risk that a patient would not get the right radiological image at the right time. When we visited the hospital on the unannounced part of the inspection, a new procedure had been written and implemented, whereby a request would be vetted before a booking was made.
- Where invasive procedures were used in the diagnostic imaging department, staff used the World Health Organisation (WHO) Surgical Safety Checklist for Radiological Interventions. This reduced the risk of harm during operative procedures, by using consistently applied evidence-based practice and safety checks to all patients.
- We saw 'pause and check' posters in the X-ray room, which reminded staff to check information about the patient. This reduced the risk of someone receiving the wrong image and unnecessary exposure to radiation.

Mandatory training

- Mandatory training included a mix of computer based modules and practical face-to-face modules. Some modules needed to be completed by all staff, including basic life support, child protection, customer service, data protection, emergency management fire safety,

health and safety, infection control and information security. Other mandatory training was specific to a staff member's role, for example acute illness management, blood transfusion, consent and immediate life support.

- At the time of the inspection, the registered manager was unable to give us an accurate figure for mandatory training because of issues with the reporting system. This had been identified by the hospital in May 2016. However, it had not been resolved at the time of the inspection. This meant that the hospital was unable to provide accurate details of how many staff had completed mandatory training modules.
- The hospital told us it had a target of completing 100% of mandatory training. Information later provided by the hospital showed that 49% of staff in the outpatient department, 83% of staff in the diagnostic imaging and 63% of staff in the physiotherapy department had completed the mandatory training relevant to their roles. This was significantly below the hospital target of 100%.

Assessing and responding to patient risk

- Staff knew how to respond if patients became unwell while they were in the department. The emergency team and resident medical officer (RMO) would be alerted to attend whichever part of the hospital the call was made from. We were told that a patient would be stabilised and moved to the ward where the resident medical officer would decide whether to transfer a patient by ambulance to the local NHS hospital. If a child became unwell, an ambulance would be called for them to be transferred to the local NHS hospital.
- There were emergency call buttons in all the clinic rooms to alert the emergency team. Each member of the emergency team wore a badge indicating their role in the team.
- Staff in the outpatient department were aware of the hospital's policy for when children had appointments in the department. If a child had an appointment in the department, a chaperone was required for every appointment and the matron or outpatient manager of the department was alerted, so they could be present in the department.
- All staff were required to complete basic life support and paediatric basic life support training as part of their mandatory training. Nursing staff in the outpatient department and radiographers also completed immediate life support training. Information provided by the hospital showed that only 50% of outpatient staff had completed basic life support training, 100% had completed paediatric basic life support and none of the nursing staff had completed immediate life support training. One hundred per cent of radiographers had completed basic life support training. Sixty-six per cent of physiotherapy staff had completed basic life support training, but none had yet completed paediatric basic life support training. While paediatric immediate life support training was not part of the mandatory training, a number of managers we spoke with said they were attending training later in the month.
- Staff in the diagnostic imaging department asked patients if they were pregnant or if there was a chance they could be pregnant, including confirming the date of the last menstrual period, if appropriate.
- The diagnostic imaging department gave a questionnaire to patients having MRI or CT scans and took a blood test for patients having a contrast agent. This meant the service was able to reduce the risk to patients who may have allergies, renal or heart complications or may have had previous reactions to contrast media or were pregnant.
- We saw that the imaging department had local rules for the imaging rooms and the mobile X-ray machine, which is in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000. This reduced the risk of equipment not being used properly.
- The diagnostic imaging department told us it had a process for taking urgent action if there were abnormal findings in a scan or image. If a radiologist found abnormal findings, they contacted the referring clinician and recorded it on the risk and incident management programme. A flowchart setting out the actions required was displayed in the department.
- Diagnostic imaging department staff told us they had a procedure for checking that referring clinicians had received and read the results of scans and images. Receiving clinicians had to sign to confirm they had received the image or report. This reduced the risk that results were not received or patients having delays to treatment.
- The hospital had a service level agreement with a company who provided the radiation protection advisor. This ensured independent scrutiny of whether the hospital was complying with IR(ME)R regulations. Staff told us they had good access to the radiation protection

advisor. The head of the imaging department was the radiation protection supervisor for all of the areas. We saw evidence they had received the appropriate training.

Nursing staffing

- There was no set guidance for safe staffing levels in the outpatient department. Staff told us the outpatient staff rota was determined based on the clinics running each day. Some clinics required more nursing and healthcare support than others. Nursing and healthcare assistants were responsible for completing the rota, which was agreed by the manager. Staff in the outpatient department told us they felt there were usually enough staff in the department to safely cover the clinics.
- Information provided by the hospital showed that on 1 July 2016, the outpatient department employed 3.6 whole time equivalent (WTE) nursing staff and 3 WTE health care assistant. At the time of the inspection, the department had recruited more nursing staff.
- The outpatient department did not use any agency staff, but used bank staff to cover shifts which were not covered by permanent staff. The hospital had an induction policy, which set out the mandatory training which all staff, including bank staff, had to complete before starting at the hospital or in exceptional circumstances within the first two weeks.

Medical staffing

- There were 100 doctors and dentists with practicing privileges at the hospital between July 2015 and June 2016. However, of the 100 doctors, only 54 had more than 10 episodes of care within the same period. This meant that 46 consultants used the hospital infrequently, which may increase risk to patients, as they are unfamiliar with hospital policies, procedures and equipment. In the outpatient department, consultants with practicing privileges used the department's clinic rooms to hold their clinic. We were told that a consultant using the clinic rooms would hold a clinic every two weeks or more frequently.
- Consultants were expected to provide evidence of their experience and competence to provide care and treatment to patients as part of the practicing privileges applications. The majority of consultants were employed elsewhere in substantive posts in the NHS.
- The hospital had a resident medical officer (RMO) on site 24 hours a day, who could provide medical support to the outpatient, diagnostic imaging and physiotherapy departments. The provision of RMOs was outsourced to an external company.

Allied Health Professional staffing

- The diagnostic imaging department employed three contracted radiographers and had one member of bank staff. The physiotherapy department employed three contracted physiotherapists and had one member of bank staff. The hospital had an induction policy, which set out the mandatory training which all staff, including bank staff, had to complete before starting at the hospital or, in exceptional circumstances, within the first two weeks. Staff in the diagnostic imaging department also received an induction for the department. Staff told us the hospital induction for bank staff was a condensed version of the induction for contracted staff.
- The diagnostic imaging department completed a rota one month in advance, based on the activity in that week, for example if consultants had specific clinics requiring more support.

Emergency awareness and training

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

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate effective, as we are not currently confident we are collecting sufficient evidence to rate this key question.

Evidence-based care and treatment

- Care and treatment within the outpatient department was delivered in line with evidence-based practice. We saw examples of Ramsay Health Care UK group-wide policies referring to national professional guidance and standards. For example, the Standard Infection Control Precautions policy referred to guidance from the National Institute for Health and Care Excellence (Infection: Prevention and control of healthcare-associated infections in primary and

community care (2012)) and the Royal College of Nursing (Sharp Safety: RCN Guidance to support the implementation of the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013).

- The diagnostic imaging department referred to National guidelines from the Royal College of Radiologists and complied with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 in its advice and procedure documents for staff. The department had a suite of policies and guidance which specifically related to compliance with IR(ME)R. There was evidence that the department carried out audit of referrals every three months and the procedures to ensure compliance with IR(ME)R.
- The diagnostic imaging department used diagnostic reference levels to monitor the radiation doses received by patients from each scan. We reviewed the electronic database of scans carried out in the department which held information about the dose for each patient.

Pain relief

- In the outpatient department consultants were able to provide prescriptions to patients who required pain relief. Some of the procedures in the department were carried out under local anaesthetic.
- The physiotherapy department had an extracorporeal shockwave therapy (a non-invasive treatment) service for the management of joint pain.

Patient outcomes

- The diagnostic imaging department carried out imaging audits every three months, to check whether the department was carrying out images of the correct area, were following the correct protocol and if the image quality was correct.
- The physiotherapy department carried out yearly audits of the clinical care and services, which evaluated whether the physiotherapists were using outcome measures for patients. In the most recent audit we saw that the department was assured that outcome measures were being properly used. The department also told us it was collecting data on the number of sessions patients needed and compared the data with other physiotherapy departments within the Ramsay Health Care UK group. This was used as a measure of the effectiveness of its treatment.

Competent staff

- The hospital used a Ramsay Health Care UK group-wide induction policy, which set out the induction process. New starters were given an induction handbook and a checklist, which was completed with their manager. We spoke with staff who had completed the induction process within the last year and told us it had given them sufficient information to start their role in the hospital and that they had been supported through the process by their manager. In the diagnostic imaging department we saw evidence in the staff files that new starters were assigned a 'buddy' to support them through the induction.
- We reviewed staff records in the outpatient and diagnostic imaging departments and found a record of the competencies of each member of staff, which had been signed by their manager and the training they had completed.
- Staff in the diagnostic imaging department had all attended external training on radiation protection provided by the organisation, who also provided the radiation protection adviser.
- Information provided by the hospital showed that 100% of eligible staff in the diagnostic imaging and physiotherapy departments and 66% of eligible staff in the outpatient department had had an appraisal within the last year (two of the three eligible staff had had their appraisal). Not every staff member was eligible for an appraisal, for example if the staff member had worked at the hospital for less than a year.
- Staff in all departments told us they were supported by their managers in their continuing professional development. Staff in the outpatient department had been supported to go on external training courses and to be part of the resuscitation team.
- Staff in the diagnostic imaging team had been given additional responsibilities in the department, such as quality assurance work, and were given the opportunity to develop competencies in different areas of imaging, such as MRI and CT. We were told that one of the radiographers was taking a radiation protection supervisor course, so they could cover the manager while she was on leave.
- We were told that in the physiotherapy department there was dedicated time at every monthly team meeting to deliver continuing professional development sessions.

Requires improvement

Outpatients and diagnostic imaging

- The diagnostic imaging department held a record of all the non-medical referrers, for example physiotherapists requesting an X-ray image. This set out their scope of practice and included copies of their radiation protection committee certificate.
- See information under this sub-heading in the surgery section for the arrangements for granting and reviewing practising privileges.

Multidisciplinary working

- The diagnostic imaging and outpatient departments were staffed by a range of professionals working together as a multidisciplinary team, to provide comprehensive service to patients.
- Staff in the outpatient department said there was a good working relationship between nursing staff, health care assistants and consultants. Likewise staff in the diagnostic imaging department said there was a good relationship between radiographers, radiologists and administrative staff.
- In the outpatient department clinic letters were routinely sent to the patients' GPs; we saw evidence of this in the medical records we reviewed. The diagnostic imaging department told us it shared results with patients' GPs and planned to audit this.

Seven-day services

- The outpatient and diagnostic imaging departments were open from 8am to 8pm on Monday to Friday. The diagnostic imaging department opened on Saturdays between 9am and 2pm if there were patients listed for ultrasound procedures.
- The imaging department had an on-call radiographer available 24 hours a day, seven days a week for X-ray.

Access to information

- All images in the imaging department were stored on an electronic picture archiving and communication system (PACS), which was accessible by radiographers and consultants with practicing privileges.
- The imaging department had access to an image exchange portal, which enabled the service to securely access and share images with NHS or other independent hospitals.
- All of the hospital policies and procedures were stored on the intranet or shared computer folders, which were accessible by relevant staff. Printed copies of policies and procedures and meeting minutes were available in the staff areas of each of the departments. We saw that staff had to sign that they had read new policies that had been introduced in their departments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All clinical staff were expected to complete a module on informed consent as part of their mandatory training which covered consent and the Mental Capacity Act (2005). Information provided by the hospital showed that none of the staff in the departments had completed this training at the time of the inspection.
- The hospital used a Ramsay Health Care UK group wide consent policy, which we saw addressed situations where patients lacked the ability to give consent. In the imaging department, written consent was taken by radiologists for any interventional procedures.
- Staff we spoke with had different levels of understanding of the Mental Capacity Act and consent. Some staff had a good understanding of the Mental Capacity Act, while others only had a basic understanding. In the outpatient department there was a grab pack with information about the Mental Capacity Act. Staff knew where this was and told us they would refer to this if they needed additional information.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- All of the patients we spoke with during the inspection spoke positively about the staff in the hospital and they also said that staff were caring.
- Staff told us patients always came first. All the staff we spoke with said that being caring towards patients was the most important part of their job.
- We observed staff in the outpatient department communicating and interacting with patients in a professional and compassionate way. We saw staff being polite, professional and warm with patients, before and after treatment.

Requires improvement

Outpatients and diagnostic imaging

- The outpatient, diagnostic imaging and physiotherapy departments used the friends and family test for NHS patients. The friends and family test is a measure of whether someone would recommend the service to their friends and family. In the months of May, June and July 2016, 100% of the outpatients who were asked said they would be likely or extremely likely to recommend the hospital to friends or family.
- People who completed the friends and family test said that staff in the departments were 'professional', 'lovely', 'friendly', 'reassuring' and 'kind'.
- We observed that staff took steps to promote patients' dignity. The reception desk for the outpatient department was located far enough away from the seating area so patients' conversations could not be overheard. All clinical activity in the outpatient departments took place in individual consulting rooms or treatment rooms and doors were closed to maintain privacy and confidentiality.
- The hospital used a Ramsay Health Care UK group-wide policy for using chaperones for appointments. The policy set out the procedure for offering and using chaperones. We saw posters in every clinic room informing patients that they could ask for a chaperone for any appointment. Staff were knowledgeable about when chaperones should be used, for example during appointments for children.

Understanding and involvement of patients and those close to them

- Patients we spoke with during the inspection told us clinicians gave them appropriate information about their care and treatment. Patients told us they were given information about the treatment options available to them and were involved in the decisions.
- Patients we spoke with told us the letters from the consultant and results of tests were sent to their GPs and they were sent a copy.
- Staff told us patients were given the telephone numbers of the department where they could speak directly to a member of the nursing staff if they had any concerns after an appointment.
- Physiotherapy patients who responded to the friends and family test between May and July 2016 said they were given 'excellent advice' and staff were able to 'answer all [their] questions and fears'.

Emotional support

- Staff we spoke with understood the emotional impact care and treatment could have on patients. In the outpatient department, staff gave us examples of where they had taken patients into private rooms and given them support after they have been given bad news or were upset following an appointment.
- In the outpatient department, information leaflets were given to patients about their condition or the procedures they were having. The outpatient department stocked a large range of leaflets for different conditions and treatment. This meant that patients were able to support themselves and be informed about their care and treatment.
- In the diagnostic imaging department leaflets about tests, such as MRI or CT, were sent with the letter confirming the appointment. This meant that patients were informed and able to prepare for the test.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital offered a range of 12 different specialities of outpatient clinics to meet the needs of the local people. Between July 2015 and June 2016, of the specialities offered, 73.2% of appointments were for trauma and orthopaedic surgery, 6.8% for general surgery, 5.8% for gynaecology, 5.6% for dermatology, 2.3% for ear, nose and throat, 2% for gastroenterology, 1.9% for ophthalmology, 1.8% for urology and less than 1% of appointments were for cardiology, general medicine, plastic surgery and rheumatology.
- The hospital offered outpatient clinics to people of all ages, which meant the needs of local children were met. While outpatient appointments were offered to children at the time of the inspection, the diagnostic imaging and physiotherapy department only took patients who were over 18 years old. Younger patients were referred to the NHS or alternative independent health private provider of diagnostic imaging.
- The outpatient department had facilities for treatment to be carried out, without needing to be admitted as an

inpatient. There was one treatment room where a range of procedures was carried out, such as wound dressing, dermatological procedures, gynaecological procedures and plastering.

- Staff told us the frequency that consultants held clinics in the outpatient department was reviewed by the hospital. However, the hospital was restricted from increasing the number of clinics, due to the limited number of clinic rooms.
- In the diagnostic imaging department, the number of days that the mobile MRI was sited at the hospital had been increased in the last year to meet the additional demand for the service. The department was also planning to increase the number of clinics held on a Saturday to reflect demand for ultrasound services and the recruitment of new radiologists by the hospital.
- The departments were all open between 8am and 8pm on weekdays, giving people of working age the flexibility to attend before or after work. However, there may be less flexibility for outpatient appointments, depending on the speciality or consultant a patient needed to see.
- The hospital did not have any 'one stop shop' clinics, although we were told that patients at outpatient appointments requiring an X-ray would have it at the same time. This meant they did not have to return to the hospital. The hospital would also try to arrange a CT or MRI at the same time as an appointment, if possible, although this was dependant on whether the mobile MRI or CT was at the hospital at the same time as a patient's clinic was being held.
- The waiting areas for all of the departments had sufficient chairs to accommodate patients waiting for an appointment.
- Hot and cold drinks were available in the outpatient department's waiting area. There was a TV and newspapers in the area also. This meant that patients and their family members could be comfortable while waiting for appointments.
- Although the outpatient department had appointments for children, there were no toys or games for children in the department. This meant there were no facilities to keep children occupied while they were waiting for their appointment.

Access and flow

- There were 27,868 outpatient attendances between July 2015 and June 2016; of these 93% were NHS funded and 7% were funded by insurance or self-paying patients.
- Between July 2015 and June 2016, the hospital consistently met the national standard of 92% of incomplete pathway patients beginning treatment within 18 weeks of referral. Each month, 100% of patients began treatment within 18 weeks of referral. This is a measure of NHS patients who are waiting to receive treatment.
- Between July 2015 and June 2016, there were nine patients who waited longer than the six week target for diagnostic imaging tests being completed (one CT scan, three ultrasound scans and five DEXA scans (a type of X-ray that measures bone mineral density). The target is that no NHS patient should wait longer than six weeks.
- Staff in the outpatient department told us the longest time someone would have to wait for an appointment would be two weeks, usually because they wanted to see a specific consultant. They said that it would be sooner if patients were happy to see the next available consultant.
- Patients we spoke with said they were given some flexibility and choices when they arranged their appointments in the outpatient department. NHS patients were able to use the Choose and Book system if they were referred to the hospital by their GP. This is a system that allows NHS patients to choose where and when to receive their treatment.
- Staff in the imaging department told us there were always free slots in the imaging lists to accommodate emergency requests.
- Patients we spoke with said that the appointments usually ran on time. Patients responding to the friends and family test also said they were seen promptly in the outpatient and diagnostic imaging departments.
- Staff told us that if a clinic was running behind by more than ten to 15 minutes, they would apologise to patients waiting for that clinic and keep them updated about the progress of the clinic. Staff gave an example of one of the clinics which was running behind on the day of the inspection, because the consultant was delayed as a result of a road traffic accident. Staff told us that they did not routinely monitor delays to clinics, so they could not tell us how often or how delayed clinics were.
- If a patient did not attend an appointment the individual consultant was responsible for deciding whether to book a further appointment for a patient or discharge them.

Meeting people's individual needs

Requires improvement

Outpatients and diagnostic imaging

- Staff we spoke with understood the importance of supporting people with additional needs, such as dementia or a learning disability. However, staff told us there were very few patients who used the hospital who had additional or complex needs.
- The training schedule the hospital gave us explained that staff received training in dementia, which was provided by an independent provider. Information given to us by the hospital showed that 37.5% of outpatient staff and 100% of eligible staff in the diagnostic imaging and physiotherapy departments had completed this training. Staff told us a dementia screening tool was used for patients having surgery at the hospital. A record of this was kept in the patient's medical records, which was accessible by staff in the outpatient department.
- The hospital used a translation service, providing face to face and a telephone based translation services. In the outpatient department and diagnostic imaging department, the telephone based service was generally used for appointments. Staff we spoke with had a good understanding of how to access the service.
- The hospital was able to arrange transport for NHS patients who were otherwise unable to attend the hospital. Staff told us this could be arranged via the GP, if it was needed. There was also a bus stop outside the hospital, so patients could visit the hospital easily on public transport.
- Free car parking was available in the hospital car park. However, during our inspection we found at times there were no available spaces. Some patients we spoke with also told us that they sometimes had difficulty finding a space. The hospital told us it was in the process of building additional spaces. The physiotherapy department had its own spaces, which meant that patients with reduced mobility did not need to walk far to get to the department.
- Staff told us the hospital would not accept bariatric patients for surgery at the hospital, so there were few bariatric patients who used the department.
- The hospital scored 72% for the patient-led assessments of the care environment (PLACE) for food between February and June 2016. This was lower (worse) than the England average for independent hospitals, which was 91%.
- The hospital scored 77% for the patient-led assessments of the care environment (PLACE) for disability between February and June 2016. This was lower than the England average for independent hospitals, which was 81%.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section for information about the hospital's complaints procedures.
- Staff in the outpatient and diagnostic imaging departments we spoke with had a good understanding of the complaints procedure and were confident about telling someone how to complain. We reviewed a record of complaints received by the hospital in the year leading up to the inspection and there were no trends or patterns of complaints relating to the outpatient, diagnostic imaging or physiotherapy departments.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement.

Vision and strategy for this core service

- There was a corporate strategy and vision called the 'Ramsay Way'. This strategy and vision set out behaviours and values expected of staff working for the organisation.
- There was also a local strategy called the Northern Blitz Spirit. This involved hospitals within the northern regional team working together to determine subjects or areas to tackle over the period of the year.
- Staff we spoke with in all departments had a poor knowledge of Ramsay Health Care UK's and the hospital's vision and strategy. None of the staff we asked mentioned the 'Ramsay Way' or the 'Northern Blitz Spirit' when we asked them about the strategy and vision.
- In the diagnostic imaging department, the manager had been in position for around a year. We were told that during this period of time, the strategy had been to ensure there were procedures in place for a safe and effective service. We were told that plans to grow the service were restricted by the size of the department.

Requires improvement

Outpatients and diagnostic imaging

- The manager of the outpatient department told us that plans for the outpatient department included developing the staff and the service. The service planned to increase the number of outpatient clinics, such as for ophthalmic and spinal surgery. The department had plans to build a soundproof room, which could be used for audiology appointments.
- The manager of the physiotherapy department told us the strategy was to develop the services offered. In the last year, the department had started an orthopaedic hand service and the use of extracorporeal shock wave treatment (a non-invasive treatment for joint pain). The department planned to start a knee service and Pilates classes within the next year.

Governance, risk management and quality measurement

- The service governance, risk management and quality measurement processes are the same throughout the hospital. Governance, risk management and quality measurement processes were not operated effectively by the senior management team. Risk management was not understood or practiced effectively at the hospital. There was a clear corporate governance structure in place. However, senior managers at the hospital were unable to tell us how they reviewed and brought together different streams of governance to inform risk management, such as internal incident review, thematic review of complaints data and review of incident data. We have reported more about these processes under this section of the surgery service within this report.
- Managers from each of the departments attended the clinical governance committee where audits, risk and new policies were discussed and the head of department meetings where staffing, audits, complaints and incidents were discussed. They also attended or sent representatives to the health and safety committee and monthly lessons learned meetings. The manager of the outpatient department (who was also manager of the surgical ward) attended the medical advisory committee (MAC).
- A clinical governance report was prepared by the hospital every three months, which summarised key performance indicators, serious incidents, patient satisfaction surveys, NICE guidance and national patient safety alerts and audits. We reviewed the April to June 2016 report, which documented issues relevant to the outpatient, physiotherapy and diagnostic imaging departments, such as the results of radiology audits.
- Departments held their own team meetings, in which information was fed back from the hospital-wide meetings. We were told that the outpatient department held team meetings every six to eight weeks and the diagnostic imaging and physiotherapy departments held meetings every month. We reviewed minutes of the most recent diagnostic imaging and outpatient departmental meetings, which followed a standard format. Minutes of the meeting were sent by email to all staff in the diagnostic imaging department, as staff needed to sign that they had read the minutes.
- The Ramsay Healthcare UK group held a radiation protection committee with regional representatives. The hospital could escalate issues to the radiation protection committee via its regional representative. Minutes of the radiation protection committee were displayed on the staff noticeboard in the diagnostic imaging department.
- Individual risks in the departments were recorded on a register of risk assessments. We were told that if a risk could be mitigated by a risk assessment, it was recorded on the departments risk assessment register. For each risk, the severity and likelihood was assessed giving a risk score. There was a risk assessment setting out the action needed to mitigate the risk and the risk score with the action taken. Each of the risks was reviewed yearly.

Leadership and culture of service

- Managers in the outpatient, imaging and physiotherapy departments were experienced clinicians in the area they managed. Staff told us that the departmental managers were supportive of them in their roles. Managers told us that teamwork and staff development were important to them.
- Staff knew who the senior management team were and said they were visible and would visit the departments. Staff said this had improved within the last year when the general manager had moved offices from an annexe to the main building.
- All the staff we spoke with were confident about speaking out to their line managers or the senior

management team if they had any concerns about their departments. The hospital used a Ramsay Health Care UK group-wide whistle-blower policy, which protected staff who needed to speak out about safety concerns.

- While the staff sickness rate was generally low, in April 2016 there were very high levels of staff sickness rates in the outpatient department. Managers in the department told us this was incidental and there were no particular reasons for the higher sickness at this time.
- Staff in all the departments told us that staff morale was good at the time of the inspection. Staff in the outpatient department told us it had improved since new staff had been recruited. Staff in the diagnostic imaging department said it had improved since the new manager started. All the staff in the diagnostic imaging department we asked, told us the department worked well as a team.
- Staff told us the turnover of staff had dropped significantly within the last year. This was supported by information provided by the hospital, which showed that between July 2015 and June 2016, no nurses or healthcare assistants had left the outpatient department.

Public and staff engagement

- The public and staff engagement are the same throughout the hospital. We have reported about the public and staff engagement under this section of the surgery service within this report.
- The hospital used the friends and family test for NHS patients. Patients were asked if they would recommend the hospital to their friends and family. While results were positive (in May, June and July 2016, 100% of patients using the outpatient department said they were extremely likely or likely to recommend the hospital to friends and family), participation was very low (in each month 1% or fewer of eligible patients completed the survey).
- One of the staff members in the diagnostic imaging team received a hospital award for excellence and a regional award for excellence. For the regional award a buffet lunch was given for all staff in the hospital.

Innovation, improvement and sustainability

- We did not identify any particular areas of innovation within outpatients and diagnostic imaging.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that an appropriately qualified and competent member of staff is present at all times to care for patients when they are anaesthetised.
- The hospital must ensure that all staff complete the relevant mandatory training for their roles.
- The hospital must ensure that it has an accurate and contemporaneous system to record the completion of mandatory training.
- The hospital must ensure that all staff providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely, including bank and agency workers.
- The hospital must ensure that staff have undertaken life support training relevant to their role.
- The hospital must ensure that there is at least one member of staff with up to date advanced life support training on duty in theatre recovery at all times.
- The hospital must ensure that controlled drugs are managed safely and correctly in line with legislation and national guidelines.
- The hospital must ensure that medications are stored safely and properly.
- The hospital must ensure that equipment is replaced from the resuscitation trolleys if it is past the manufacturer's use by date and that checks identify equipment which is past the manufacturer's use by date.
- The hospital must ensure that patient risk assessments and pre-operative anaesthetic assessments are completed and documented correctly.
- The hospital must ensure that all staff who have contact with children, young people and/or parents/carers, have completed level two safeguarding children training.
- The hospital must ensure that all clinical staff complete level two safeguarding adults training.
- The hospital must ensure that staff receive training in consent, Mental Capacity Act and Deprivation of Liberty Safeguards.
- The hospital must ensure that it maintains a complete, accurate and contemporaneous record of patient care and treatment.
- The hospital must ensure that systems and processes are operated effectively to assess, monitor and mitigate risks to patients, including maintaining a robust risk register.
- The hospital must ensure that systems and processes are operated effectively to assess, monitor and improve the quality and safety of services provided.
- The hospital must ensure that action plans from audits are implemented and monitored to address areas of poor compliance and to improve patient outcomes.

Action the provider SHOULD take to improve

- The hospital should ensure that all staff receive an appraisal in line with Ramsay Health Care UK policy.
- The hospital should ensure that all rooms are cleaned and cleaning schedules are completed for every room in the outpatient department.
- The hospital should ensure that all clinical waste is correctly stored, managed and disposed of in the outpatient department and that the sluice room is securely locked when not in use.
- The hospital should ensure that the programme to remove carpets in outpatient clinic rooms is completed.
- The hospital should consider how to reduce the reliance on temporary staffing in theatres.
- The hospital should consider the arrangements for securing the paediatric resuscitation trolley in the outpatient department.
- The hospital should consider the arrangements for storing and securing the emergency drugs which were stored in the diagnostic imaging department.
- The hospital should consider how to increase the numbers of staff receiving dementia training.
- The hospital should consider putting a system in place to record when patients do not attend an appointment.
- The hospital should consider ways to increase patient feedback and engagement

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People who used the service were not protected against the risks of abuse and improper treatment because staff had not received the correct level of safeguarding training.** Regulation 13(1)(2)(3)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not ensure that hospital staff had access to all necessary information,including maintaining an accurate, complete and contemporaneous record in respect of each patient and of decisions taken in relation to the care and treatment provided.** Regulation 17 (2) (c)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users receiving the care or treatment. The provider did not do all that was reasonably practicable to mitigate any such risks. The provider did not ensure the persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The provider did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a, b, c, g)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not operated effectively to enable the provider to assess, monitor and improve the quality and safety of the services provided. Systems and process were not operated effectively to enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17(1) (2) (a, b)