Rowley Hall Hospital

Quality Report

Rowley Hall Drive
Stafford
ST17 9AQ
Tel: 01785 238600
Website: www.**rowleyhallhospital**.co.uk

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

Ratings

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

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

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

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Rowley Hall Hospital is located in a Georgian listed building in five acres of Rowley Park, Stafford. The hospital opened in 1987 and currently has 13 ensuite bedrooms and 10-day case pods. The hospital is managed by Ramsay Healthcare UK Operations Ltd and is part of a network of over 36 hospitals, day surgery facilities and two neurological rehabilitation homes across England. In addition, they run hospitals in Australia, Indonesia and France.

We inspected the core services of surgical services and outpatients and diagnostic services as these incorporated the activity undertaken by the provider at this location.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 12 October 2016, along with unannounced visits to the hospital on 20 and 27 October 2016.

We rated both core services, and the hospital as good overall. However, we found that safety in surgical services required improvement because we had concerns that that safety checks in theatres were not consistently completed and infection rates for spinal and breast procedures were higher than the national average.

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 core service.

We rated this hospital as good overall because:

- Governance arrangements ensured that surgery was planned and co-ordinated effectively. Incidents were reported and investigated; staff felt incidents were dealt with appropriately and feedback was given. Staff told us they felt valued and listened to.
- Staff were caring and supported patients to make informed decisions based on sound clinical options. Staff had a genuine interest in the health and wellbeing of their patients. Patients were complimentary about the care they received pre and post-operatively.
- Patients with complex needs were supported and their carers encouraged to attend the hospital with them.
- The hospital had systems in place, which ensured that patients were protected from the risk of avoidable harm.
- Services were effective, practice was audited and learning shared to improve patient outcomes. Recognised pathways of care, and national guidance were understood and followed.
- Services were responsive to patients' individual needs. The patient journey from one department to another was easy and waiting times were minimal.

We found areas of practice that require improvement in both surgery and in outpatients and diagnostic imaging services.

- Surgical safety processes were not embedded in theatres.
- Staffing in theatres was not in line with surgical first assist perioperative care collaborative guidelines. Staff undertaking the role had not completed the recognised training requirements and undertook dual roles for procedures greater than a minor operation.
- Not all staff who worked in recovery were trained in Advanced Life Support (ALS) which meant good practice guidelines were not being followed. Not all staff were clear about how to respond in emergency situations and update training had not been received.

Summary of findings

- Staff were not up to date with mandatory training.
- The audit process in theatre had not been effective; the newly employed theatre manager was in the process of building a robust team of appropriately trained staff
- Only 34% of nurses working in outpatients had currently received an annual appraisal.

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 requirement notices that affected surgery. Details are at the end of the report.

Ellen Armistead
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Surgery	Good		We saw incidents were reported, investigated, feedback given and learning applied. Infection control and prevention processes were in place and recorded rates of infection were low. Treatment and care was provided in line with national guidance. All patient feedback was positive. Individual patient discharge arrangements were re-discussed with each patient on admission. Staff meetings took place with minutes recorded and logged on the intranet. However, surgical safety processes were not embedded in theatres and some staffing was not in line with surgical first assist perioperative care collaborative guidelines. Staff undertook dual roles for procedures greater than a minor operation. Not all staff who worked in recovery were trained in Advanced Life support (ALS) which meant good practice guidelines were not being followed. Mandatory training levels were below the hospital target of 100%. Not all staff were clear about how to respond in emergency situations and update training had not been received.
Outpatients and diagnostic imaging	Good		Staff were skilled and experienced in their roles and new staff were supported to ensure they developed the required skills. Services were effective, practice was audited and learning shared to improve patient outcomes. Recognised pathways of care, and national guidance were understood and followed. Staff were caring and supported patients to make informed decisions based on sound clinical options. Staff had a genuine interest in the health and wellbeing of their patients. Services were responsive to patients' individual needs with the patient journey from one department to another offering minimal waiting times. Systems were in place to support patients with complex needs. The departments were well led, staff felt supported and practices were monitored to ensure patients received safe, high quality care.

Summary of findings

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Good

Rowley Hall Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Rowley Hall Hospital

Rowley Hall Hospital is located in a Georgian listed building in five acres of Rowley Park, Stafford. The hospital opened in 1987 and currently has 13 ensuite bedrooms and 10-day case pods. The hospital is managed by Ramsay Healthcare UK Operations Ltd and is part of a network of over 30 hospitals, day surgery facilities and two neurological rehabilitation homes across England. In addition, they run hospitals in Australia, Indonesia and France.

The hospital offers a wide range of treatments and services. There are two fully equipped theatres with ultra clean air technology providing facilities for a range of surgical procedures. The hospital is registered for surgery, cosmetic surgery, endoscopy, diagnostic imaging and refractive eye surgery. The site provides outpatient consultations, a radiology service, and imaging and physiotherapy services for adults aged over 18 years only.

Care is available for NHS-funded and private patients. Private patients are either self-funding or have their fees paid by their insurance companies. Patients funded by the NHS referral system account for 89% of patients.

There are 68 consultants working at the hospital under practising privileges; none are directly employed by the hospital. Eighty-five health professionals, administrative and clerical and support staff are employed by the hospital.

At the time of the inspection, a new manager had recently been appointed but had not commenced employment therefore was not registered with the CQC.

The hospital is registered to provide the following regulated activities:

- Diagnostics and screening procedures.
- Surgical procedures
- Treatment of disease, disorder, or injury

We have inspected this hospital once previously. Our last inspection was undertaken on 05/11/14, there was one compliance action made following this inspection relating to management of medicines - Outcome 9 (Regulation 13). This was followed up through a desk top review in January 2014; the provider supplied sufficient evidence to give CQC assurances that the issues had been addressed.

Our inspection team

The team that inspected the service comprised a CQC Inspection manager, three CQC inspectors, and a specialist advisor with expertise in theatres.

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

Information about Rowley Hall Hospital

During the inspection, we spoke with 10 patients, both NHS and privately funded, and 12 members of staff including nurses, support staff, physiotherapists, radiologists and department managers. We met with the hospital senior managers, service leaders and spoke with consultants who use the service. We looked at eight sets of patients' records. We visited all clinical areas and observed direct patient care and treatment.

We attended the hospitals quarterly Medical Advisory Committee (MAC) meeting on 19 September. We held a planned focus group with staff on 4 October to allow staff to share their views with the inspection team. These included clinical and non-clinical staff.

The hospital has 13 individual patient bedrooms each with en-suite facilities, open 24-hours a day, and ten-day

case pods. There are two operating theatres with ultra clean air-flow systems. The hospital does not carry out emergency surgery; all operating procedures were planned.

Rowley Hall Hospital outpatients department offers cosmetic, dermatology, endoscopy, and gastroscopy, general surgery, gynaecological, ophthalmology, orthopaedics, pain management, podiatry, spinal and urology services.

The department has six consultation rooms, two treatment rooms, two preoperative assessment rooms and a private patients' lounge.

Imaging services comprise of a general x-ray room for outpatients. Computed tomography (CT) and magnetic resonance imaging (MRI) services are provided on set days each week within specialist mobile units run by a different provider. We did not inspect them.

The physiotherapy department has four treatment rooms and a gym offering rehabilitation as an outpatient service.

The hospital also offers cosmetic procedures such as dermal fillers, laser hair removal and ophthalmic treatments. We did not inspect these services.

University Hospitals North Midlands is the nearest NHS acute trust. The County Hospital is less than 2 miles from Rowley Hall.

Activity (July 2015 to June 2016)

- There were 5,795 inpatient and day case episodes of care recorded at this hospital; of these 91% were NHS funded and 9% were other funded. The largest proportion of these episodes were day case, accounting for over 85%.
- Thirteen percent of all NHS funded patients and 31% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 29,973 outpatient total attendances; of these 100% were NHS funded.
- No one under the age of 18 years was treated at the hospital as either an inpatient or outpatient.

Staffing

- There were 68 doctors working at the hospital under practising privileges.
- Two regular resident medical officers (RMO) worked on a fortnightly rota.
- The hospital employed 27.3 (WTE) registered nurses, 14.4 Operating Department Practitioner (ODP) and health care assistants (WTE) and 43.8 other staff.
- The accountable officer for controlled drugs (CDs) was the manager of the acute ward.

Track record on safety

- No never events or serious injuries reported in the period July 2015 to June 2016.
- There were 93 clinical incidents reported in the period July 2015 to June 2016. We saw that 79 resulted in no harm, 13 low harm, 1 moderate harm and none resulted in severe harm or death.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), or hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA) were reported in the period July 2015 to June 2016.
- No incidences of hospital acquired Clostridium difficile (C.Diff) were reported in the period July 2015 to June 2016.
- No incidences of hospital acquired Escherichia –Coli were reported in the period July 2015 to June 2016.
- The hospital received 32 complaints in the period July 2015 to June 2016.

Services provided at the hospital under service level agreement:

- Blood collection
- Courier service
- Laundry
- Grounds maintenance
- Pathology
- Pharmacy
- Offsite Storage Medical Records
- RMO International
- Security

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?

Requires improvement

We rated safe as requires improvement because:

- Surgical safety processes were not embedded in theatres.
- Staffing in theatres was not in line with surgical first assist perioperative care collaborative guidelines. Staff undertaking the role had not completed the recognised training requirements and undertook dual roles for procedures greater than a minor operation.
- Not all staff who worked in recovery were trained in Advanced Life Support (ALS) which meant good practice guidelines were not being followed.
- Not all staff were clear about how to respond in emergency situations and update training had not been received.

However:

- Incidents were reported, investigated, feedback given and learning applied.
- Infection control and prevention processes were in place and recorded rates of infection were low.
- NHS Safety thermometer data measured 'harm free' care.
- Staffing levels were planned and implemented to keep people safe.
- Medical cover for patients was appropriate. A resident medical officer was available out of core hours, to aid with medical emergencies, which meant that there was 24-hours a day seven days a week medical cover.
- There was a service level agreement for the transfer of an acutely ill patient to the local NHS hospital, should the need for this arise.
- Hand hygiene audit results across the hospital achieved 93% overall (April 2016).
- We saw evidence of radiology standard operating procedures, quality assurance audits and no safety issues identified following the 2016 annual radiology protection advisor’s (RPA) audit report.

Are services effective?

Good

We rated effective as good because:

- Treatment and care was provided in line with national guidance and processes were in place to update policies and procedures.

Summary of this inspection

- Rowley Hall Hospital patient reported outcome measures (PROMs)relating to primary knee replacements (87%) and primary hip replacement (80%) was within the estimated range.
- Pain scores were assessed and recorded to demonstrate patients' comfort and the effectiveness of pain relief
- Effective multidisciplinary teamwork was demonstrated across the hospital
- The imaging department adhered to the Ionising Radiation (Medical Exposure) Regulations and to the Ionising Radiation Regulations 1999.
- The hospital had procedures in place to monitor the competences of staff and medical practitioners.
- Staff were aware of their duty when obtaining consent, adhering to the Mental Capacity Act and consent was clearly documented in patient records.

However:

- The audit process in theatre had not been effective; the newly employed theatre manager was in the process of building a robust team of appropriately trained staff
- It was evident that confusion arose regarding pre-operative fasting when then the order of the theatre list changed. Staff appeared unaware of the action to take when this happened. Not all staff we spoke with were fully aware of the national guidance for pre-operative fasting of two hours for clear fluids and six hours for solids.
- Only 34% of nurses working in outpatients had currently received an annual appraisal.

Are services caring?

Good

We rated caring as good because:

- All patient feedback was positive confirming that respectful, professional staff maintained their privacy and dignity at all times
- The hospital welcomed all feedback to continually improve the patient experience
- We observed that staff were courteous, polite and friendly when responding to patients' individual needs.
- Patients told us they were given good explanations of their treatments and were given opportunity to ask questions.

Are services responsive?

We rated responsive as good because:

Summary of this inspection

- There was timely access to appointments for patients within outpatients and radiology and patients were able to choose appointment times, including outside normal working hours.
- Individual patient discharge arrangements were re-discussed with each patient on admission
- Patients with complex needs were risk assessed
- Patients with special needs such as those living with dementia or with learning disabilities were fully assessed and information conveyed to ward staff to ensure their needs were met during their inpatient stay.
- Translators were booked in advance for appointments to assist patients whose first language was not English.
- Patient leaflets were available in different languages and in large print if required.
- Clinic rooms in outpatients and toilets were accessible to those with mobility problems such as patients using wheelchairs.
- Complaints were well managed and the hospital director offered to meet with complainants to discuss their complaint.

Are services well-led?

Good

We rated well-led as good because:

- A strategic plan ensured that all levels of the organisation were working in line with the strategic goals.
- Staff meetings took place in departments and hospital-wide. Minutes were recorded and logged on the intranet.
- There were clear governance structures with evidence of incidents, complaints, the risk register and clinical outcomes being regularly reviewed.
- There was effective, visible leadership and staff told us they felt valued and well supported.
- The new role of the quality improvement lead and new matron would increase focus on quality improvement at the hospital.
- The hospital had mechanisms in place to collect and act on feedback from the public.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Requires improvement

Incidents

- Staff understood their responsibilities to report incidents internally and externally. They described how they would raise concerns, record and report safety incidents including near misses. All levels of staff were encouraged to report incidents. When an incident with harm occurred to a patient, a root cause analysis was completed, an action plan was produced and learning was cascaded at the hospital's Medical Advisory Committee (MAC) meetings and in department weekly briefings. This ensured all staff were aware of recent events and the action taken.
- On induction, staff received training to use the hospital's electronic reporting system using their own log in code. Feedback to staff was part of the incident reporting process. Staff confirmed they were aware of investigation conclusions in their feedback.
- There were no never events reported in the reporting period July 2015 to June 2016. A never event is a serious, largely preventable patient safety incident that should not occur if healthcare providers have implemented the available preventative measures.
- Seventy-one clinical incidents in surgery and inpatients were reported between July 2015 and June 2016, which was in line with other independent acute hospitals; 0% severe, 1% moderate, 14% low and 85% no harm.
- Fifteen non-clinical incidents occurred in surgery and inpatients between July 2015 and June 2016, which was similar to the rate for other independent acute hospitals.
- One serious injury, relating to orthopaedic surgery occurred between July 2015 and June 2016, was reported to CQC in February 2016. We saw that the incident was investigated, Duty of Candour was applied and action plans developed and completed.
- No in-patient deaths were reported between July 2015 to June 2016.
- Mortality and morbidity reviews and the findings were discussed through the MAC meetings. Relevant information was shared with the appropriate consultant and department staff.

Duty of Candour

- Duty of Candour (DOC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff understood their responsibilities with regard to the duty of candour legislation and the need to display openness and transparency with their patients when things went wrong.
- The Ramsay Group had a corporate policy entitled; 'Being open policy' dated October 2015 and staff told us they were aware of this policy.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The safety thermometer was not displayed in the hospital. The data included pressure ulcer incidents, falls, venous thromboembolism (VTE) or blood clots and

catheter-acquired urinary tract infections (CAUTI), Clostridium Difficile (C.Diff), medication incidents, complaints and 'Friends and Family Test' (FFT) returns. The NHS Safety Thermometer is a tool used to measure, monitor and analyse patient harm and harm free care it applies to NHS patients only

- No incidences of hospital acquired VTE occurred between July 2015 to June 2016; VTE screening rates were above 95%.
- There were no falls reported during the same reporting period and 100% harm free days.

Cleanliness, infection control and hygiene

- The hospital's infection control committee met monthly to discuss their annual plan and review audit data. Minutes of the meeting were on the intranet and made available to us.
- The hospital's patient-led assessment of the care environment (PLACE) score of 99% for cleanliness was the same as the England average. (February to June 2016)
- In-patient rooms and day case pods were visibly clean, tidy and obstruction free. In theatres, the anaesthetic rooms, theatre suites and storerooms were visibly clean, tidy and complied with the Ramsay theatre cleaning policy HS088. The staff room and changing rooms were clean and well organised.
- Carpet flooring in the in-patient bedrooms was visibly clean; domestic staff explained how the carpets were cleaned according to the schedule and method statement, ensuring that carpets were deep cleaned between each admission and immediately upon any spillage.
- The infection prevention and control environment audit dated February 2016 scored 84% overall. The audit identified non-compliance with incomplete cleaning rotas and rust on equipment in theatre.
- We saw that areas of bare plaster were exposed in both theatres and one laminate work top was damaged in the theatre two anaesthetic room. This had not been addressed when we revisited for the unannounced inspection.
- Policies and procedures were available on the hospital's intranet to manage infection prevention and control.
- Compliance with infection, prevention and control policies was observed in all cases except one surgeon, who was seen to wear their suit jacket on the day unit. This did not comply with the Department of Health's 'bare below the elbow' guidance and the hospital's policy. The hospital told us that since the inspection, consultants with practising privileges at the hospital have each received a letter reminding them of the hospital dress policy. On the unannounced inspection, we found the required dress code was complied with.
- We saw that good hand hygiene was practiced in all areas of the wards and theatre. Hand washing facilities and hand gel dispensers were sited around all areas. Hand hygiene audits conducted in the reporting period July 2015 to June 2016 showed an average compliance score of 93%. An action plan to improve compliance was put in place when scores of 80% were achieved on two occasions.
- The Infection Prevention and Control Environmental Audit (February 2016) scored 84%. Incomplete cleaning rotas, theatre cleanliness and equipment in need of replacement, reduced the overall score.
- We observed staff using personal protective equipment (PPE), such as aprons and gloves, appropriately. Foot operated bins were used to avoid hand contamination.
- There were no cases of Methicillin Resistant Staphylococcus Aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), E-Coli or Clostridium difficile (C-Diff) in the reporting period July 2015 to June 2016.
- Six surgical site infections were recorded in the reporting period July 2015 to June 2016. The rate of infections during spinal and breast procedures was above the rate of other independent acute hospitals. Three infections were reported out of 772 spinal procedures undertaken and one infection was reported from 61 breast procedures undertaken. This data was brought to the attention of the infection prevention and control lead and was recognised as being due to the low numbers reported.
- The rate of infections during upper gastrointestinal and colorectal procedures was similar to the rate of other independent acute hospitals.
- The rate of infections during primary knee procedures was lower than the rate of other independent acute hospitals.
- There were no surgical site infections resulting from primary or revision hip arthroplasty, other orthopaedic and trauma, gynaecological or urological procedures between July 2015 and June 2016.
- Decontamination of reusable medical devices was carried out in line with national guidance.

- Waste disposal complied with Ramsay policy HHS035; clinical and domestic waste bags from theatres were labelled in accordance with Association for Perioperative Practice guidance.
- Domestic staff explained how cleaning schedules were in place for individual rooms and departments and we saw these were signed and dated. Where necessary, staff were trained in Control of Substances Hazardous to Health (COSHH) and they were familiar with the hospital policy for disposal of waste. The IPC waste disposal audit of February 2016 scored 100%.

Environment and equipment

- The ward and day unit adult resuscitation trolley was easily accessible. Three months of daily safety checks records were reviewed at the inspection and all were completed with a signature noted. On checking the equipment, we found all items in date with sterile packaging intact. Oxygen, suction machines and portable equipment were clean, electrically tested and in working order.
- The hospital's PLACE score of 85% for condition, appearance and maintenance was lower than the England average of 93%. The absence of an outside seating area had been identified as an issue.
- Patient moving and handling equipment was available on the ward and had been maintained and serviced appropriately.
- We observed the manual handling slide boards stored on the floor in theatre and on the floor in the theatre corridor, which were not being stored in line with infection control and prevention guidelines. At the unannounced inspection, it was identified that equipment was stored appropriately.
- Theatres were secure with entry by key card or call bell only.
- We saw evidence that an annual laminar flow ventilation test was completed in June 2016. The results showed that the noise levels in theatre one and the anaesthetic room were described slightly above the recommended level and one inspection light was absent.
- We saw theatre equipment, including anaesthetic equipment, was clean, appropriately tested prior to use with in-date cleaning and testing stickers attached.
- The offsite hospital sterile services department ensured that appropriate equipment was available for surgeons. The system promoted the correct flow of dirty to clean equipment, which reduced the risk of contamination.
- The ‘difficult intubation’ trolley was checked weekly; contents were found in date, however the inside of drawers was dusty which was brought to the attention of the theatre staff who immediately rectified the issue.
- Implant hip and knee replacement serial numbers were documented in the patient’s theatre notes.

Medicines

- Medication was stored safely; the door to the medicines’ room was secure, with a digital code lock. Medication was locked in cupboards within the medicines’ room with the keys held by the nurse in charge.
- We saw nurses checked patients’ identification bands prior to the administration of medication, including checks for any allergies.
- Medicine administration records demonstrated that medicines had been prescribed and administered appropriately.
- Current stock ‘controlled drugs’, which require special storage and recording, were stored and handled appropriately. However, we found 12 packets of patients’ own controlled drugs had not been returned to them on discharge from up to six months previously. These were stored in the controlled drug cupboard, had been checked on a daily basis but failed to be returned to the patient or appropriately destroyed. The pharmacist was in discussion with the general manager to organise their destruction, which the hospital confirmed as completed after the inspection.
- The Ramsey medicines management audit of December 2015 scored 100% and the controlled drug audit completed at the same time scored 62%. The scoring system resulted in a reduced score as there was no on site pharmacy support at the hospital.
- The Ramsey medicines management re-audit of April 2016 scored 100%. The controlled drug re-audit of June 2016 removed the non-applicable scoring system and the score of 94% was achieved. The hospital had since employed their own pharmacist who monitored stock control, reviewed the in-patients medications and was making plans to re-audit the controlled drug process.

- The refrigerator and the medicines room temperature were recorded to ensure they remained within acceptable limits to store medicines. Staff reported any temperature discrepancies to the maintenance team to ensure the medication was stored correctly.

Records

- Staff used a paper-based records system for recording patients' care and treatment.
- The hospital's medical records management policy (dated 2015 for review in 2018) ensured effective keeping and handling of records so that treatment and services were effectively monitored and audited. The policy reflected legal requirements in relation to records and confidential information, including the security afforded to the records to ensure that confidentiality.
- Patients' medical records were stored securely in locked trolleys with care plans and observation charts stored in the patient's room ensuring confidentiality.
- We looked at eight patient records including pre assessment notes, investigations results, treatment and care provided. Entries were signed, dated and a patient details label was on each page.
- Care pathways commenced following individual risk assessments such as risk of falls, immobility and diabetes. The hospital's care pathways audit completed in May 2016 average score was 74%; variances not being recorded caused the score to be below the target of 100%. Re-auditing was planned to take place in the New Year.
- Anaesthetists recorded their assessment on the anaesthetic sheet including the patient's height and weight and American Society of Anaesthesiologists (ASA) Physical Status classification score. The March 2016 ASA audit score was 92% against a target of 100%.It was identified that oxygen had not been prescribed correctly, nil by mouth status was not recorded and some fluid balance charts were incomplete.
- Theatre records were completed appropriately in the six we reviewed. The January 2016 theatre organisational management audit scored 87% overall, against a target of 100%.

Safeguarding

- Reflecting relevant legislation, suitable arrangements, including policies and procedures were in place to safeguard adults from abuse and avoidable harm. Staff were aware of the reporting process, had received training and they were able to described to us how they would respond to a concern. The policy included guidance for staff on domestic abuse and female genital mutilation.
- The hospital safeguarding lead, who was qualified to level three, was responsible for attending local safeguarding meetings, ensuring staff were suitably trained and ensuring all hospital safeguard information was up to date.
- Non-clinical staff underwent level 1 adult safeguarding training and clinical staff received level 2. Hospital training records showed that 50% of clinical staff had completed their training. The hospital shared with us their action plan for safeguarding training and extra sessions had been scheduled to ensure all staff would meet the target by the end of 2016/2017.
- Staff had not reported any safeguarding concerns between July 2015 and June 2016.

Mandatory training

- Heads of departments (HODs) and administration managers monitored staff's compliance with expiry dates for mandatory training. There was also a training lead, who had an overview of those who required training and they would remind the HODs when staff training was due.
- Mandatory training was delivered face to face and via electronic online learning. Mandatory 'update' training records for clinical staff currently identified low compliance levels in basic life support 52%; Fire safety 47% and infection control 45%.
- An action plan to address the low compliance of training updates had been developed and department heads reported their progress at the weekly management meeting. The target of 100% was planned to be achieved by the year-ending 2016/2017.
- Bank staff mandatory update training records also identified low compliance levels, between 2% and 43%. Basic life support was currently 5%; Fire safety 9% and infection control 9%. The management acknowledged the low completion score. They planned to include bank staff training (completed by their main employer), which would increase training compliance levels significantly.
- We were told that online mandatory training (e-learning) could be completed at any time, when hospital activity allowed, or by logging in from home and claiming the time back.

- New staff completed all mandatory training prior to starting with the company where possible or soon after commencement. Continual professional development training was available for clinical staff.

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

- We found some inconsistencies with theatre staffs' application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist. Not all stages were carried out correctly or recorded as the checklist procedure stipulates. For example, not all persons were present for the sign out and introductions in theatre were not fully completed. Whilst observing the checklist the checklist was not fully completed on all occasions. We observed one patient's identification was not confirmed prior to insertion of a cannula and one patient's allergy state was not always re-checked.
- The WHO checklist was audited by the hospital and showed high levels of compliance but used the paper record only and did not include any observational audits of the process. For example, the May 2016 surgical safety checklist audit score was 97%.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) state that at all times there should always be at least one member of staff present who is Advanced Life Support (ALS) trained. An anaesthetist should always be available to attend immediately, who will provide further ALS trained 'cover' for emergencies in the recovery area. However, the anaesthetist does not require to be physically present at all times. At the hospital, we found that not all nurse or operating department staff were trained to ALS level. We observed that the anaesthetist did remain in theatres whilst the patient was in recovery. An action plan had been introduced to train all staff to ALS by end of January 2017.
- Since the inspection, the management team had reviewed the WHO checklist. We visited theatres on two separate occasions as part of the unannounced inspection. We observed that all staff took part in the process, except for the theatre introductions. Introductions took place in the team huddle at the beginning of the day; however, these were not repeated in each individual theatre in line with the hospital policy.
- Following the unannounced inspection senior managers informed us they have attended theatre to observe the completion of the WHO checklist. The managers reported that the process was observed to be inconsistent with subsequent observation sessions improving on a daily basis. We were informed that this observational audit would continue as part of the quality and safety audit process.
- Patients booked for a procedure at the hospital completed a questionnaire, which assisted the clinic staff to decide the level of pre-admission assessment required.
- Patients were assessed either via telephone or in hospital, using the patient admission criteria to ensure optimum patient safety. When a patient's pre-operative findings were outside the admission criteria, they were referred to the local acute hospital for their care and treatment. Patient care pathways recorded post-operative observations including wound care. By undertaking routine clinical observations, the staff ensured that early identification of sepsis was recognised. The RMO told us that the staff were vigilant and notified them when a patient showed signs of an infection.
- Staff used the National Early Warning system (NEWS) system, a nationally recognised tool to identify deteriorating patients at the earliest opportunity. This tool alerted clinical staff to any vital signs that fell out of safe parameters for the patient's normal scores. This information was then alerted to the RMO and or the consultant as necessary. A service level agreement with the local NHS hospital ensured safe management of deteriorating patients.
- When a patient's condition deteriorated, staff told us they followed a service level agreement (SLA) with the local NHS hospitals. The SLA for the Emergency Transfer of Critically Ill Patients from the Independent Sector (Rowley Hall Hospital) to NHS Care ensured staff could recognize when a patient became seriously ill and immediately respond to their needs. The document clearly stated the staff's responsibilities and procedures to follow.
- Between July 2015 and June 2016, there were two unplanned transfers of patients to the acute trust via the emergency service.
- Procedures were in place for ensuring blood required for elective surgery was available at all times. We saw that the blood refrigerator temperatures and contents were checked and recorded daily.

- Nurses used a nationally recommended handover process known as 'SBAR'. SBAR stands for situation, background, assessment and recommendation. We saw that the details were documented when discussing a patient's condition with a clinician.

Nursing and support staffing

- The ratio of nurses to health care assistants was 10:1. There was no bank and agency nurses booked for the ward throughout September 2015 to June 2016. In July and August 2015 use of bank and agency staff was slightly higher than average of other independent acute hospitals.
- We saw that staffing in theatres was not in line with Perioperative Care Collaborative Guidelines on the role of the surgical first assistant (SFA). The roles of SFA is to provide continuous support to the operating surgeon throughout the procedure. The guidelines state the person undertaking the SFA role must have undertaken a nationally recognised programme of study and be an additional member of the surgical team. The SFA should not assume additional duties, unless the organisation consider a "dual role" is required and this must be set out in a policy.
- The hospital's theatre operational policy stated that all theatre staff must have evidence of completion of competencies relevant to their role and that dual roles could be undertaken for procedures considered to be minor operations, this was in line with the Perioperative Care Collaborative Guidelines.
- We found that not all theatre practitioners acting as the SFA had completed or commenced a programme of study and/or demonstrated the relevant competencies required. We immediately brought this the attention of the general manager who immediately took action and enrolled six members of the theatre team onto an NVQ programme. We saw documentary evidence to confirm this.
- During the inspection, we directly observed one procedure being carried out where staff had "dual roles" during a procedure that would not be considered a minor operation. We reviewed the theatre records for both theatres and found that staff had been undertaking "dual roles" on other procedures. We were assured at the unannounced inspection that these issued had been appropriately rectified with staff being reminded about their role.
- Patient handovers took place at the beginning of each shift. The staff received information about all the patients; the named nurses then introduced themselves to their patients and reviewed their care plan.
- The hospital only undertook elective surgery, which meant the number of nursing, and care staff required on any particular day could be calculated and booked in advance depending on the patients to be admitted. Duty rotas were completed four weeks in advance and reviewed on a daily basis. The required skill mix was arranged when the admissions were finalised using the hospital acuity tool.
- There was no staff turnover for inpatient nurses or healthcare assistants in the reporting period July 2015 to June 2016.
- All operating department practitioner's (ODP) working at the hospital were registered with the Health and Care Professions Council (HCPC). The HCPC is an independent UK regulatory body responsible for setting and maintaining professional standards for a number of different healthcare professionals and social workers.
- Sickness rates for theatre ODPs and health care assistants were similar to the average of other independent acute hospitals we hold this type of data for in the same reporting period.
- The sickness rates for nurses working in inpatient departments were higher than the average of other independent acute hospitals we hold this type of data for in the reporting period July 2015 to June 2016.
- The sickness rates for health care assistants working in inpatient departments compared to the average of other independent acute providers we hold this type of data for in the same reporting period.
- There were no vacancies for nurses or health care assistants in inpatient departments and other staff working in the hospital as at 1 July 2016.
- The vacancy rate for theatre nurses was higher than the average of other independent acute hospitals. One 'full time equivalent' post vacant gave a vacancy rate of 14%.
- The vacancy rate for theatre ODPs and health care assistants was higher than the average of other independent acute hospitals. One vacant FTE post gave a vacancy rate of 10%.
- The rate of theatre nurse, ODP and health care assistant turnover was above the average of other independent acute providers that we hold this type of data for in the

reporting period July 2015 to June 2016. The hospital's management had completed a successful recruitment drive and no vacancies were reported at the time of the inspection.

Medical staffing

- A resident medical officer (RMO) was available 24 hours per day, to aid with medical emergencies. Consultants were available out of hours for advice or attendance.
- The rotational RMO post ensured that the hospital had suitable cover. Each RMO was on duty two weeks on and two weeks off. They had an arranged formal handover scheduled in to their time.
- Handovers were an essential part of the day in all departments of the hospital. The RMO attended the ward, theatres and recovery to review the patients awaiting surgery and post operatively. The RMO also reviewed patients prior to them returning to the ward.
- Consultants working under practicing privileges therefore were not directly employed by the hospital. Practising privileges is an established process in the independent sector where a medical practitioner is granted permission to work in the private hospital once they have fulfilled certain criteria with regards to the skills and individual competencies. In line with the 'practising privileges agreement' consultants were contactable at all times when they had inpatients. This successful agreement required each consultant to make suitable arrangements with another consultant to provide cover when they were not available.
- The RMO and nurses told us that consultants were always available for a telephone review 24 hours a day, seven day a week and in attendance within 30 minutes should an emergency event arise. To ensure effective planning and continuity of the service each consultant was required to provide a minimum of six weeks' notice to attend training, courses or to take leave.
- Staff told us and we saw that an up to date out of hours consultant on-call list was available on reception with a second nominated colleague noted.

Emergency awareness and training

- The business continuity management plan was created to counteract interruptions to Ramsay Health Care UK business activities and to protect critical business processes from the effects of major failures or disasters.
- The policy stated that staff received training on the emergency procedures and process, including incident handling, business continuity and IT disaster recovery, both when appointed to a position, and as part of ongoing training and regular testing.
- We were not assured that staff were familiar with the business continuity plan and policy. Those we spoke with had not received recent update or scenario training. However, staff told us they were aware of whom to alert in case of emergency. For example, staff would contact the on call manager for business issues.

Are surgery services effective?

Evidence-based care and treatment

- Treatment and care was provided in line with national guidance and governance processes were in place to update policies and procedures.
- Hospital staff followed local policies, procedures and care pathways including specific consultant pre and post-operative preferences for hip and knee replacement.
- Care and treatment was in line with national guidance, such as that issued by the National Institute for Health and Care Excellence (NICE), including CG50, the monitoring of the acutely ill patient for deterioration, routine preoperative tests for elective surgery NG45 and laparoscopic surgery for inguinal hernia repair TA83. New guidance was corporately acknowledged and received by the relevant services.
- The audit programme was completed and reported annually in the hospital 'quality account' report.

Pain relief

- With the anaesthetists' advice the theatre staff reviewed the prescribed pain relief prior to each patient's transfer to recovery or the ward. Staff were encouraged to contact the RMO or the consultant when additional pain relief was requested.
- Patients told us their pain control had been managed well. Three patients we spoke to on the ward told us they were pain free and had been frequently asked if they were in pain.

- Staff told us and the patients we spoke with confirmed that analgesia was discussed during the preadmission appointment.
- Pain scores were recorded on patients' NEWS charts to demonstrate the patient's comfort and the effectiveness of pain relief. Pain relieving medicines were prescribed on the patients' administration charts and given when required.

Nutrition and hydration

- Patients had access to drinks and snacks at all times; they reported that the food quality and portions were above what they had expected. Hot and cold drinks were offered throughout the day and night.
- In line with European Society of Anaesthetic guidelines individual 'fasting' advice was discussed at each pre-admission assessment and confirmed in writing. Specific pre-operative protocols were in line with each consultant's request; this ensured that fasting was in line with their preferences for the safety of the patient and not longer than needed.
- The hospital's pre-operative fasting policy stated that all patients should be given written information about the arrangements for starving prior to their surgery. It was evident that confusion arose when the order of the theatre list changed as staff appeared unaware of the action to take when this happened. Not all staff we spoke with were fully aware of the national guidance for pre-operative fasting of two hours for clear fluids and six hours for solids.
- We looked at two completed fluid balance charts, which recorded the times and amounts of fluid that the patient had received and their recorded urine output was appropriate.
- The hospital's 2015 PLACE audit identified a score of 94% for ward food, which was above the England average of 92%.

Patient outcomes

- Patient reported outcome measures (PROMs)assess the quality of care delivered to NHS patients from the patients' perspective. PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys for hip replacements and knee replacements. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.
- PROMs results for primary knee replacements carried out at Rowley Hall Hospital were within the expected range. From 50 records, 80% reported as improved and 8% as worsened.
- Primary hip replacement for Rowley Hall Hospital was within the expected range. From 92 records, 87% reported as improved and 4% as worsened.
- The hospital submitted data to the Private Healthcare Information Network (PHIN) and the National Joint Registry scheme (NJR). Two hundred and seventy one primary procedures and nine revision procedures were forwarded to the NJR scheme.
- Out of 56 results for the Oxford Knee Score, 95% were reported as improved and 4% as worsened. The Oxford Knee Score is a 12-item patient audit designed and developed to assess function and pain after total knee replacement surgery. Out of 103 records, the Oxford Hip Score reported 97% as improved and 3% as worsened.
- PROMS groin hernia could not be fully calculated, as there were fewer than 30 records for the measures. Out of 27 records, 44% were reported as improved and 22% as worsened.
- Two unplanned inpatient transfers to another hospital were recorded between January and June 2016.
- There was one case of unplanned readmission within 28 days of discharge reported between July 2015 and June 2016.
- No cases of unplanned return to the operating theatre were reported between July 2015 and June 2016.

Competent staff

- The hospital monitored consultant compliance in preparation for their appraisal. Proof of revalidation, renewal and indemnity was required as a part of the practising privileges process. The General Medical Council revalidation code for consultants demonstrated their competence with NHS consultants providing evidence of mandatory training from their NHS employer.
- There were 68 consultants working under practising privileges at the hospital. Practising privileges is a well-established process whereby a medical practitioner is granted permission to work in a private hospital.

- Ramsay Health Care policy stated that it was the general manager's responsibility to contact individual consultants three months in advance of their pending expiry of any element of their practising privileges, and remind of the process for re-applying, before review at the medical advisory committee (MAC).
- We looked at six randomly selected personnel files for medical practitioners and found that all had current appraisal information; Disclosure and Barring Service data (two were dated 2012). All the files we looked at had up to date revalidation information.
- Induction training was mandatory for all new starters providing them with an overview of all hospital areas. Newly recruited trained staff were supernumerary to the ward and theatre staffing levels during their planned induction, which was tailored to their previous experience.
- Student nurses' mentors supported their experience and ensured their placement met the university requirements.
- Each member of staff was responsible for identifying any competencies they wished to maintain. Continual professional development (CPD) sessions were arranged and individual requirements were supported for nurse revalidation.
- One hundred per cent of staff appraisals were completed for health care assistants (HCAs) working in inpatient departments, operating department practitioners and HCAs working in theatre departments in the current appraisals year. In the current appraisal year 79% of staff appraisals were completed for nurses working in inpatient departments and 29% were completed for nurses working in theatre departments.
- The rolling 12-month appraisal programme was on target for all staff to have received an appraisal by their anniversary date. New employees had an appraisal at six months and then their personal development review every 12 months in line with the hospital policy.

Multidisciplinary working

- Medical and nursing staff, therapists and pharmacist staff worked professionally together on the ward and in departments. Ward rounds took place on a daily basis.
- Multidisciplinary teamwork was demonstrated with shift handovers, good communication and precise record keeping. Patients' individual needs were discussed during pre-admission appointments, including planned treatments and therapies with physiotherapists.
- The RMO described staff as responsive to the patients' needs and explained how they contacted them appropriately for advice and in a timely way.
- When patients were discharged, the hospital worked well with external services. A letter was sent to the patient's GP on discharge to inform them of the treatment and care that had been provided. Post discharge advice booklets were given to the patients advising them on post-surgery information such as rest, pain, sleep, hygiene, wound healing and work.

Seven-day ward

- Consultants visited their patients daily as part of the pre and post-operative care pathway. The nursing staff told us they had no hesitation in contacting consultants at any time to discuss their patient's condition or care.
- Theatres were flexibly available in a seven day service open from 8am to 8pm Monday to Friday and from 8am to 6pm on a Saturday and Sunday.
- To support emergency events, theatres were available for emergency purposes 24-hours a day, seven days a week; each night theatre staff and a senior manager was on an 'on call rota'.
- Physiotherapy service was available Monday to Friday 8am to 5.30pm with inpatient ward cover at weekends as needed.
- An out-of-hours 'advice only' pharmacy service was available.

Access to information

- Nursing records were accessible in each patient's own room with medical records stored in locked trolleys.
- Policies were accessible on the intranet, referenced good practice guidelines and, in most cases, up to date.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Written consent for surgical procedures was in line with Ramsay consent policy CN004 as consent was obtained at pre-admission assessments or on the day of surgery. Two patients we spoke with told us the consultant had discussed the procedures during their assessment and they had been given time to consider them before consenting. Consents were checked again on the ward and in the anaesthetic room.
- Staff explained the procedures they followed for those patients who lacked capacity to consent to their treatment including involvement of those close to the patient. No specific training had been received.

Surgery

Good

- Ramsay Healthcare policies for the resuscitation of patients stated all patients that had a cardiac arrest were to be resuscitated. There were no 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms in place within patient's records at the time of our inspection.

Are surgery services caring?

Compassionate care

- The friends and family test (FFT) score for the hospital was recorded as 100% between January 2016 to June 2016. Response rates varied between 18% and 76%. Response rates are for Independent Sector NHS patients only.
- Patients we spoke with told us they observed the staff to be professional, caring and they communicated well. From pre-admission to post-operative time we were told that the experience was such they would recommend the service wholeheartedly
- Comments received on the inpatient survey cards included positive feedback, for example "excellent care", "well looked after" and "very friendly, staff very professional and such a positive experience".
- The hospital sought patient feedback from an external patient satisfaction survey. Positive and negative feedback from patients was sent to the general manager and ward manager each Friday for prompt attention and distribution. Negative comments were actioned with a phone call to the patient to ensure resolution. For positive feedback, the general manager sent 'thank you' cards to patients as appreciation for the time they took to complete the survey.

Understanding and involvement of patients and those close to them

- Patients told us they felt they were fully informed to make decisions about their treatment.
- We saw that staff provided information in a way patients understood. Patients told us they had the reason for admission, including the risks involved, explained to them during their pre-assessment appointment and again on admission. They told us the consultant ensured they fully understood the reason for the surgery or procedure. Patients followed the same admission process and received the same information for day care or inpatient care.

Emotional support

- Religious or spiritual support was available if an inpatient requested it.
- We saw staff explaining post-operative care to a patient in a way they understood.
- In theatre, we observed the anaesthetist and ODP reassuring a patient in a sympathetic way, alleviating their fears.
- When required, counselling services were arranged for patients being treated as an outpatient.
- Visiting times were specified; however when necessary this could be flexible depending on the physical and emotional needs of the individual patient.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The hospital did not provide emergency care; all admissions were planned.
- The general manager met with the local trusts and Clinical Commissioning Group to discuss the NHS support required to meet referral targets and ensure patients were seen within acceptable parameters.
- Services were planned and delivered to meet patients' needs. Admission dates were arranged during patient pre-admission appointments, taking in to consideration their individual choice and availability of inpatient or day unit beds.
- The general manager, manager and directors met weekly to plan staffing, operating lists and future admissions. Special requirements, such as the need for an interpreter were identified through booking forms and pre-assessment along with discharge arrangements.
- The physiotherapists attended the ward on a daily basis to review patients' physical progress with the nursing staff.
- Individual patient discharge arrangements were re-discussed with each patient on admission.

Good

Surgery

- Individually devised physiotherapy regimes were created depending on the surgical procedure and post-operative consultant instructions.

Access and flow

- The hospital's admission process was the same for private and NHS patients.
- Between July 2015 and June 2016, the hospital achieved the NHS target of 90% of admitted patients beginning treatment within 18 weeks of referral. During the same period, the hospital met the 95% target of non-admitted patients beginning treatment within 18 weeks of referral.
- Ninety-eight per cent of NHS patients were treated within 18 weeks of referral to treatment. NHS waiting times for surgery were monitored locally, corporately and nationally with weekly updates received corporately.
- Private patients were treated within a timescale agreed with the consultant in line with waiting list and management of patients accessing NHS treatment policy.
- There were 182 procedures cancelled for a non-clinical reason between July 2015 and June 2016. The hospital told us that 59 were due to absence of equipment and 40 were listed as consultant issues. The other reasons included staffing issues and late finish times. All affected patients were offered another appointment within 28 days of the cancelled appointment.

Meeting people's individual needs

- Inpatients were allocated a private bedroom, with en-suite facilities, a television and individually controlled heating.
- The hospital's PLACE score of 80% was lower than the England average for privacy, dignity and wellbeing (England average 83%).
- Ward and day unit nurses escorted patients to theatre and collected them from recovery.
- Single sex accommodation requirement was 100% compliant.
- Inpatients were assigned a nurse at the beginning of a shift to ensure continuity for the patient.
- Staff gave information leaflets to patients to ensure they were fully informed about their procedure or the surgery, clearly explaining the risks and benefits.
- With the support of the multidisciplinary team and precise planning, staff made arrangements for special requirements for dealing with patients with complex needs including learning disabilities.
- Patients with special needs such as those living with dementia or patients with learning disabilities were identified at the pre-assessment clinic. Further assessment was carried out of their needs in conjunction with the patient's family/carer. The ward staff were then informed to ensure patients' needs were met during their inpatient stay.
- Patients requiring the support of their own carers or relatives were pre-arranged.
- Interpreters were booked in advance for appointments to assist patients whose first language was not English.
- Patients with complex needs were risk assessed by physiotherapists and their care plans were based on their risk assessments and professional advice.
- Dietary preferences were noted and a choice of meals was offered. Hot and cold drinks were offered throughout the day.

Learning from complaints and concerns

- We saw that 'how to make a complaint' booklets were freely available around the hospital.
- Staff were encouraged by managers to view complaints as a positive learning process. Patients who raised concerns received both an apology and thanks for providing a valuable opportunity to review and improve the service the hospital offered.
- Concerns could be raised verbally, electronically and informally through verbal feedback. Resolution methods included telephone calls or the offer of a meeting with the hospital director.
- Formal complaints were responded to with an acknowledgement letter or telephone call within two working days. Complaints were discussed at the senior management team (SMT) meetings, weekly heads of departments meetings, monthly governance meetings and MAC meetings. Staff told us that any lessons learnt or improvements in practice from complaints were logged on the intranet.
- Anonymised scenarios taken from complaints were used to share with staff during customer care training.
- There were 32 formal complaints received in the reporting period July 2015 to June 2016. One theme related to wait times for patients undergoing minor procedures such as endoscopy. Because of the feedback, the hospital introduced staggered admission times to ensure wait times were minimal.
- One complaint was received by the CQC between July 2015 and June 2016 that related to suitability of surgery.

Good

Surgery

- No complaints were referred to the Parliamentary and Health Service Ombudsman or Independent Healthcare Sector Complaints Adjudication Service in the same reporting period. The assessed rate of complaints was lower than the rate of other independent acute hospitals for which we hold this type of data.

Are surgery services well-led?

Good

Vision and strategy for this this core service

- Ramsay Healthcare UK Operations Ltd and Rowley Hall Hospital were committed to deliver high quality outcomes for patients and ensuring long-term profitability. A strategic plan ensured that all levels of the organisation were working in line with the strategic goals for the coming two years. The strategy, developed in a poster format, was discussed at departmental meetings ensuring goals were met and delivered. The vision included being the healthcare provider of choice, being committed to offering fast access to the service, being efficient and growing the revenue.
- An external survey company questioned staff on their understanding of the company vision and the communication filtered down by the SMT. Staff were able to discuss the vision and strategy, pointing out the poster which they were familiar with.
- Leadership meetings incorporated the strategy in to their agenda, ensuring a collaborative approach to the strategic direction relevant to the hospital.
- The management provided staff recognition and appreciation of teamwork, they aimed to achieve positive outcomes for patients and staff alike.
- The hospital had a set of core values known as 'The Ramsay Way'. These were to ensure staff were caring, took pride in their work, valued integrity, credibility and respect for patients, to build constructive relationships to achieve positive outcomes and believe that success comes through recognising the value of staff and encouraging that value through recognising professional and personal development.
- We saw that staff demonstrated these values when providing care to patients. Ramsay Health Care was committed to integrity, ownership, positive spirit, innovation and teamwork. Staff said they felt the 'Ramsay Way' was patient-centred and fitted in with their own personal values.

Governance, risk management and quality measurement

- The governance structure included risk management, group and local governance, policy framework and intranet national 'H' drive. We observed that close working relationships ensured that the teams were effective; regular meetings and referral to the MAC ensured that the vision was considered at all times and safety issues were discussed and handled robustly when necessary.
- We saw that data that demonstrated Rowley Hall Hospital complied with the corporate audit programme and the relevant heads of departments reviewed audit action plans.
- The clinical governance committee had MAC representation to ensure all lines of enquiry were discussed which relate to hospital risk and safety.
- The audit process in theatre had not been effective; the newly employed theatre manager was in the process of building a robust team of appropriately trained staff
- We attended a MAC meeting prior to the inspection. The role of the committee included approval of new procedures and equipment that consultants wanted to introduce to the hospital and reviewing quality and safety issues. We heard incidents and complaints presented and discussed, surgical procedures reviewed and risks discussed. Consultant surgeons and anaesthetists from each speciality were represented. MAC meetings were held quarterly, agendas were sent out and the previous minutes were confirmed.
- There was one risk register for the hospital, which logged all on site issues. The risk register was maintained by the senior management team and it identified corporate and local risks identified through audits and staff reporting. Reviewed on a regular basis by the SMT, all risks were RAG rated via the electronic system. The RAG system is method of rating issues, based on red, amber and green colours used in a traffic light rating system. We saw that the register reflected the concerns of staff and included a number of the issues identified during our inspection such as the training of surgical first assistants in theatres.

- All staff underwent mandatory training annually, including e learning in relation to risk and governance. Each consultant was expected to adhere to the Ramsay Facility Rules and the GMC code of conduct; this was reviewed at their annual appraisal.
- CQC received one whistleblowing alert from a member of staff in October 2015. We received documentation from the management which demonstrated that this had been fully investigated, discussed at the MAC and the issues raised were continuing to be monitored.

Leadership / culture of service related to this core service

- Staff we spoke with told us they felt listened to by their managers. They described an inclusive working culture with a family feel. Many staff had worked at the hospital for over 10 years and they were proud to display their commitment to the patients and hospital.
- During a focus group, held prior to the inspection, staff from all departments of the hospital told us they felt valued and respected by the hospital's managers and consultants.
- Staff told us the senior management team were visible and approachable. A staff member told us, "What I like about this place was I hadn't worked here long and the senior managers knew my name and said 'Good Morning'." Staff we spoke with thought the manager of the hospital was visible, approachable, friendly and a 'people person'.
- Staff development was encouraged and supported, demonstrating a learning culture in line with the continuing education policy.
- A student nurse, on placement from a local university, told us staff had welcomed them and enabled them to feel part of the team.

Public and staff engagement

- The management team told us they welcomed patient feedback and changed the service in line with patient comments. Commencement of a patient forum group was being considered to discuss issues that may have arisen and look at ways to improve the service with patient input.
- The hospital collects information from patient satisfaction surveys, direct patient feedback and insurance provider feedback. They utilise the feedback to develop action plans and improvements that were identified as being required. They scored 100% satisfaction in the latest survey available to us dated June 2016.
- Staff told us the general manager had an open door policy and the staff valued their support.
- Staff told us they could raise their issues or concerns and felt confident they would confidentially be dealt with, in a respectful way.
- Staff meetings took place with meeting minutes logged on the hospital intranet and paper copies were on the notice board. Incidents, policies and new guidelines were discussed.
- When comments about patient care were received, they were fed back to the relevant staff and staff told us that they appreciated positive feedback.
- Social media was used to connect with the public, for example "Twitter".

Innovation, improvement and sustainability

- Following a provider visit in September 2015 inspecting the hospital against the five CQC domains, an action plans were developed from the findings. A strategic plan has since been developed to ensure all staff was aware of the Ramsay objectives and future plans.
- The new role of the hospital quality improvement lead had recently been introduced (QIL) and the new appointed matron was due to start in November 2016. The general manager told us their role was to focus on quality improvement and promoting the value of lessons learnt from incidents and patient feedback.
- Newly employed staff 'orientation' was being reviewed including mandatory training, buddy programme and the "30/60/90 days" catch up tools, to ensure staff were supported.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- All staff received training on induction to enable them to enter details onto the hospital's electronic reporting system. Staff we spoke with understood their responsibility to raise concerns and record safety incidents and near misses. Staff told us they were encouraged to report incidents.
- Reported incidents were investigated and a root cause analysis was carried out. Staff were able to describe examples of incidents and the learning that had taken place. For example, the monitoring of wounds to prevent infections had improved as a direct result of incident reporting.
- From July 2015 to June 2016, the outpatient and diagnostic imaging service reported 16 clinical incidents. This was lower than the rate of other independent acute hospitals for this type of data. From the same time period the hospital reported nine non-clinical incidents in outpatient and diagnostic and imaging service. This was similar to the rate of other independent acute hospitals for this type of data.
- The outpatient and diagnostic imaging services had reported no never events between July 2015 and June 2016. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Duty of Candour

- See the Surgery section for main findings.

Cleanliness, infection control and hygiene

- Clinical staff and consultants in the outpatients department were bare below the elbows and we observed staff washing their hands and using hand sanitiser gel. Hand sanitizer gel was wall mounted, available for staff and visitors to use on entrance to the outpatients department and in each clinical room. Hand hygiene audit results across the hospital achieved 93% overall (April 2016).
- Staff and visitor's toilet facilities were cleaned regularly and contained wall mounted hand sanitizer gel.
- Staff received aseptic non-touch technique training for wound care of patients, and intravenous medication administration as part of their training. Staff and the outpatient manager confirmed this.
- The manager of the outpatients department told us that equipment used within outpatients was predominantly disposable, but any equipment that required decontamination after use, was sent to the same off site decontamination provider that the theatres used.
- We were shown a cleaning roster which documented that the rooms and waiting areas were cleaned each day. Domestic staff cleaned the department early morning and evening so as not to disrupt clinics. This included removing clinical and general waste.
- The waiting areas, treatment rooms and consulting rooms were visibly clean and uncluttered. Rooms where patients received treatment contained clean suitable furniture and flooring with wipe-clean surfaces. We were shown an equipment-cleaning matrix, which showed which staff were responsible for cleaning which piece of

equipment and the frequency of this. We saw that this was signed by staff and was complete. We saw "I am clean" labels stuck to equipment and trolleys containing recent dates when they had been cleaned.

Environment and equipment

- Equipment was maintained in good order. Equipment faults were logged and recorded via the hospital's team of maintenance engineers. Simple issues were fixed by the on-site team, but the hospital also held a number of maintenance contracts with external suppliers who would regularly visit to service and monitor specialist equipment such as call bells, and fire extinguishers.
- The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. We saw electrical testing stickers on all items of equipment that were in date.
- There were clear, well-maintained records of environmental risk assessments in respect of equipment used in outpatients and a staff member was responsible for the monitoring and updating of this.
- Staff were trained to use equipment and their competencies were assessed afterwards. Staff told us they only used equipment when they were competent to do so.
- There was an adult resuscitation trolley available in the outpatient department. We saw that this was checked daily by staff and records of checks were maintained. We checked 10 random items from the resuscitation trolley in the outpatient department and all were found to be in date with packaging intact. The resuscitation officer monitored this.
- At Rowley Hall Hospital, there was a mobile service, which supplied computerised tomography (CT), and magnetic resonance imaging (MRI) services twice a week in the hospital car park. There was a standard operating procedure (SOP) in place to ensure that a safe, professional, and high quality service was supplied to patients.
- Imaging services had an on-site radiation protection supervisor and annual visits from a radiation protection advisor, ensuring there was always a point of escalation if staff had any safety concerns.
- Outside the x-ray room, there was a sign which became illuminated when in use to indicate to staff and patients to not enter because radiation exposure was temporarily in use.
- Guidance is provided by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) for the safe use of radiological equipment. This includes guidance for operating procedures, incident reporting, training and equipment maintenance and medical physics' role. These IRMER procedures were accessible to staff on the hospital intranet and were reviewed annually.
- A radiation protection audit was completed on 30 September 2016. There were no safety issues identified but there were several recommendations for further improvements to practice. There was an action plan in place identifying how these improvements would be achieved.

Medicines

- Medicines were managed safely in outpatients and radiology. The medicines storeroom door in outpatients had a digital code lock and the combination was known only to nursing and housekeeping staff. Medicines were kept in locked cupboards within the medicines' storeroom with keys held by the nurse in charge.
- The medicines storeroom in outpatients was air conditioned and the temperature of the room monitored to ensure it remained within acceptable limits to store medicines safely.
- No controlled drugs were held or administered in outpatients or diagnostic imaging.
- Within the outpatient department blank prescriptions were available via the head of department as these were stored securely within a locked cabinet within a locked room
- Contrast materials also called contrast agents or contrast media, are used to improve pictures of the inside of the body produced by x-rays, CT, MRI and ultrasound. We found that these materials were kept locked in a wall mounted cabinet in the x-ray room and stored and administered in accordance with the standards for intravascular administration to adult patients. Contrast media was prescribed for each patient by radiologists.

Records

- There was an effective system in place for the management and safekeeping of patients' notes. These were managed electronically and on paper. Paper copies of patients' notes that were needed imminently for outpatients and radiology clinics were kept in a locked cupboard behind the reception desk. These were managed by the reception staff team.

Good

Outpatients and diagnostic imaging

- Patients' notes were also filed and kept securely within the health records department. A small, dedicated team of records staff worked alongside outpatient reception staff to ensure notes were available for clinics.
- The manager of outpatients explained that they would be piloting a new complete electronic record keeping system for the Ramsey Group. They said that they, and another staff member, would be 'super users' of the system.
- Over the three months preceding the inspection, 3% of patients were seen in outpatients without all relevant medical records being available. There were processes in place to mitigate risk if a patient attended and the records were not available. A temporary set of medical notes would be made and copies of relevant documentation inserted from the relevant electronic system. This would include copies of notes from NHS trusts if required. When the original notes were made available, the two sets would be merged to create a single set.
- If a consultant wished to take notes off-site, the hospital staff told us they would refer them to the corporate security of medical records policy.
- We reviewed six outpatient notes and these demonstrated that notes were legible, up to date and detailed the care and treatment provided to the patient.

Safeguarding

- See the Surgery section for main findings.
- Staff were aware of the process for making adult safeguarding referrals. A staff member gave an example of where they had had to raise a safeguarding concern when an adult was a risk and how this had helped to protect the patient. Staff we spoke with were able to define abuse and to identify adults at risk.
- Staff were clear about the safeguarding procedures to follow and who the safeguarding leads were. Staff had received training in adult safeguarding as part of their induction and received regular updates on this.

Mandatory training

- See the Surgery section for main findings.
- All staff within the outpatients department had an in date immediate life support (ILS) certificate.

Assessing and responding to patient risk

- Patients had to wait for a set period of time to be observed following procedures.
- The hospital had a service level agreement with a local NHS trust for the transfer of acutely ill patients.
- The World Health Organisation's (WHO) 'five steps to safer surgery' checklist was used for patients undergoing radiological procedures.
- Staff knew what to do in the event of a patient experiencing a cardiac arrest.
- A pre-admission assessment was carried out on all patients undergoing minor procedures in clinics as an outpatient. For patients undergoing surgery then a pre-operative assessment would be carried out. This assessment would identify any risks to the patient based on their medical history, whether these risks could be minimised and if the hospital could safely care for them. All referrals were screened; patients who had conditions such as unstable diabetes or high blood pressure had their procedures delayed until the issue was resolved.

Staffing

- As of 1 July 2016, there were 3.8 whole time equivalent health care assistants and 5.2 nurses working in outpatients. The staff mix for outpatients was a ratio of 1.4 nurses to one health care assistant. The outpatients' use of bank and agency nurses was minimal and no bank or agency HCAs were used.
- In outpatients, staffing was planned in advance of clinics and staff were provided in accordance with the needs of the patients. Staff members told us that they worked flexibly to fit around clinics. Staff felt that the team worked very well together and supported each other. Clinics were arranged out of hours and some on Saturdays. There were no staff vacancies in outpatients department.
- There were three contracted radiographers and two bank radiographers. Another radiographer had just been recruited and was due to start working there imminently.
- There were six contracted staff and five bank staff who worked in the physiotherapy unit. The physiotherapy unit was located away from the main building. There was a lone working standard operating procedure in the physiotherapy department and staff confirmed that they did not work alone with patients there.
- Staff held a 'safety huddle' every morning. During these meetings, staff from all of the hospital departments

shared information about anything that may affect the safety and welfare of patients. Staff told us the managers of outpatient and radiology kept them informed of relevant information from this meeting.

Medical staffing

- There were 68 consultants who had been granted practising privileges at the hospital. Practising privileges is a well-established process whereby a medical practitioner is granted permission to work in a private hospital.
- In line with the 'practising privileges agreement' consultants were contactable at all times when they had patients at the hospital. Each consultant was required to make suitable arrangements with another colleague to provide cover when they were not available.
- Consultants held regular clinics, having arranged them directly with the outpatients administration team, and were responsible for the care of their patients.

Major incident awareness and training

- See the Surgery section for main findings.
- Staff told us they were aware of corporate policies such as for adverse weather and fire evacuation. They explained these were all on the hospital's intranet and covered on their induction training.
- We saw 'Emergency Management: fire and personal safety' training was an administrative element of the 'my learning' section of the electronic mandatory training system.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

- In outpatients, protocols were in place to ensure NICE guidelines were maintained. Audits were used to monitor best practice. We saw a recent audit had been completed to review how sharps were managed within the department. We also saw an audit of wound care had resulted in better monitoring and early detection of wound infections.
- A radiation protection audit was completed by an external agency on 30 September 2016. There were no safety issues identified but there were several recommendations for further improvements to practice. There was an action plan in place identifying how these improvements would be achieved.
- We saw evidence of standard operating procedures (SOP), based on national guidance, which were in the process of being introduced in outpatients. This included a gynaecological SOP and care pathway. Ramsay Health Care had a new SOP for their outpatients' departments, that was due to be introduced in November 2016. The manager of outpatients told us they had been involved in the development of this national SOP. They said they had been able to input ideas they had for improvements, and were able to make suggestions about what would work well.

Pain relief

- Patients requiring individual pain assessments were issued with a prescription by the consultant in outpatients and were able to receive their prescribed medication from the supporting pharmacy.

Patient outcomes

- The hospital met their target of 92% of patients on incomplete pathways waiting 18 weeks or less for treatment from the time of referral in the reporting period July 2015 to June 2016. Above 95% of patients started non-admitted treatment within 18 weeks of referral in the same reporting period.
- No patients waited six weeks or longer from referral for MRI, CT or non-obstetric ultrasound in the same reporting period.

Competent staff

- Data supplied by the hospital demonstrated that between July 2015 and June 2016 in outpatients and diagnostic imaging 75% of HCAs had received an appraisal.
- For the same period, 34% of nurses working in outpatients had received an appraisal.
- The rolling 12-month appraisal programme was on target for all staff to have received an appraisal by their anniversary date. New employees had an appraisal at six months and then their personal development review every 12 months in line with the hospital policy.

- Radiology staff were Health and Care Professions Council (HCPC) registered and were able to maintain their competencies. A staff member had recently done their update training (September 2016) in order to maintain their competencies.
- Nursing staff within the outpatient department told us that it was their individual responsibility for ensuring that they were professionally up to date with their knowledge in order to achieve their annual revalidation, which formed an element of their professional registration requirements; the outpatients 'manager monitored this.
- Nursing revalidation took the form of mandatory training completion, competency checks, personal development plans, continued professional development and clinical supervision. Nurses felt supported with their professional development. Nursing staff told us they felt supported with their professional development and would not complete outpatient procedures that were outside their own scope of practice.

Multidisciplinary working

- Staff worked together to assess and plan ongoing care and treatment in a timely way as patients moved through the hospital departments. We saw how the nurses in outpatients interacted with the consultants, the medical secretaries, therapists and the ward, when liaison was required between individual and departments. This meant care was delivered in a coordinated way when different teams or services were involved.
- Patients were pleased with how they could be referred from one department to another easily. We saw patients attend outpatient clinics and then x-ray with very little waiting time. One patient said they had waited only 10 minutes from clinic to x-ray. A patient who had returned to the outpatient clinic following surgery told us, "Because it's small it works really well".
- There was good communication with GPs in respect of the care and treatment patients had received and any on-going care and support they may require. We saw consultants communicated with GPs via letters (discharge letters) and telephone calls.

Seven-day services

- Outpatients ran clinics Monday to Friday from 8 am to 8.30 pm and Saturdays from 8am to 1pm. Diagnostic and imaging services were provided during these times and could be provided as and when required.
- The radiology department was open during clinic hours but could provide 24-hour cover seven days per week as required with the use of a long-term locum radiologist.
- Within the outpatient area, consultants were available, within the constraints of their schedule, between 8am and 8.30pm during the week and 8am to 1pm on Saturdays. The outpatient department was closed on Sundays. If consultants were required urgently outside of the core working, for example in the evening or at weekends, then the resident medical officer (RMO) would be available to assess patients and provide simple interventions until the patient could be seen by their consultant. The consultants we spoke with said that they had good working relationships with RMOs.

Access to information

- Consultants, nursing and administrative staff told us that there were no issues with accessing paper based patient notes for clinics.
- Electronic access was available for pathology, microbiology and radiology results to enable timely access to diagnostic results. According to the new SOP for histology specimens, these were labelled and forms completed and were stored in the swab room until they were collected.
- Patients' specimens were collected twice a day and results were reported electronically. We saw that staff kept a diary and recorded when specimens had been sent and when results were due. If the results had not been received within the time frame than staff rang to chase these up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their duty when obtaining consent and ensured explanations were given in a way patients could understand. A staff member gave us an example of when a patient needed help with making decisions about their treatment.
- Patients felt they were given choice and understood the information provided for the decision-making. We saw that consent was clearly documented in the six patient records we reviewed.

- In discussions, staff were confident describing to us relevant consent and decision making requirements of national guidance including the Mental Capacity Act 2005. Staff had received training for safeguarding including information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- The friends and family test (FFT) score for the hospital was recorded as 100% between January 2016 to June 2016. Response rates varied between 18% and 76%. Response rates are for Independent Sector NHS patients only.
- We spoke with 10 patients within outpatients and the diagnostic and imaging departments.
- All the patients we spoke with were happy with the care and treatment they had received and were complimentary about the staff. One patient said, “It's brilliant here,” another patient told us, “It is very good, very helpful and pleasant staff.”
- All the patients told us that they were treated with dignity and respect. We observed that the reception staff maintained patients’ privacy at the reception desk. Patients were greeted by the reception staff on arrival at the hospital and guided round to either outpatients or the imaging department. Consultants called for patients and saw them in consulting rooms behind closed doors.
- Staff were seen to be available for patients if they needed any further support or a chaperone before, during or after the consultation. Patients were asked if they would like a chaperone during consultations and examinations. Staff told us they received training in how to chaperone patients. We saw that staff signed to say they had chaperoned the person in their notes. We observed that there were chaperone posters displayed in reception.
- We observed that staff were polite, courteous and friendly with patients.

Understanding and involvement of patients and those close to them

- Patients told us that they were given clear explanations about their care and treatment. They said they did not feel rushed and were given time to ask questions. A patient told us how the physiotherapist had spent time with them both pre and post-operatively and ensured they had a good understanding of what would be involved in their surgery and recovery. They told us plenty of information was given both pre and post-operatively. Other comments included, “Nothing could have been done better and I felt relaxed and cared for throughout the procedure”.

Emotional support

- Staff supported people when they were anxious. While we were speaking with the manager of the outpatients’ unit, a member of the reception staff came in and asked if the manager could come and talk with the patient as they had become anxious and upset. The manager took time with the patient to reassure them.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital marketing manager liaised with local GP surgeries to talk to them about what the hospital could offer both NHS and privately funded patients. These discussions included how they could work effectively together to achieve good outcomes for patients.
- The environment was appropriate and patient centred. There was sufficient seating available in the waiting areas where drinks were available for patients to purchase.
- The signage to the outpatient and imaging departments was not immediately clear at the reception to the hospital. However, reception staff escorted all patients to the departments on arrival. There was no signage within the outpatient departments to assist patients to find the toilets or the exits.

Good

Outpatients and diagnostic imaging

- Car parking was limited and patients told us that finding a car parking space could be a problem. This meant if clinics were delayed parking arrangements were sometimes affected.
- Evening clinics in outpatients and the imaging department were provided Monday to Friday and Saturday morning clinics to enable patient's access to appointments out of normal working hours.

Access and flow

- Referrals to treatment could be made through GPs, hospitals and self-referrals. Above 95% of patients started non-admitted treatment within18 weeks of referral.
- Patients told us they usually waited no longer than 15 minutes to be seen in clinics. There was a sign on the wall asking patients to tell the receptionist if they had been waiting longer than this. We saw that a clinic was running late and patients and staff told us this was very unusual and due to the late arrival of a consultant. Patients confirmed they had been informed about the delay.
- Patients told us that they liked how they did not have to wait long if they needed an x-ray. One patient said, "I waited 10 minutes after being told I needed an x-ray". This is what I like about it here you can have everything done all in one go and don't have to come back".
- Clinicians told us that the 'did not attend' (DNA) rate was very low. Patients who did not attend for appointments were followed up by staff and if there were any concerns about a patient's welfare there was a SOP in place for staff to follow.

Meeting people's individual needs

- Appointments at clinics were fitted in around patients' availability to attend. A patient told us that the administration staff and consultant had been "absolutely amazing and accommodating" with organising appointment dates.
- Patients with special needs such as those living with dementia or patients with learning disabilities were identified at the pre-assessment clinic. An in-depth assessment was carried out in conjunction with the patient's family/carer, to ascertain their individual needs. Staff explained to us how they supported people with a special need such as a learning disability or dementia and a staff member gave us an example of how this had been managed in the past. The manager of the unit confirmed that there was training, support and guidance for staff to follow for patients with special needs.
- Staff gave patients appropriate written and verbal information about their care and treatment in a way they could understand. When patients visited outpatients for the first time they were given an information pack including a booklet which contained information about what to expect before, during and after their treatment. Staff spoke in plain English and did not use acronyms.
- Staff had access to interpreters to assist in communicating with patients whose first language was not English. Translators were booked in advance for appointments.
- Clinic rooms and toilets were accessible to those with mobility problems such as patients using wheelchairs.

Learning from complaints and concerns

- See the Surgery section for main findings.

Are outpatients and diagnostic imaging services well-led?

Good

Vision and strategy for this this core service

- See the Surgery section for main findings.
- The outpatient manager was able to describe a clear vision for the service. This was to provide outpatient services that are always patient centred, safe, effective, caring responsive, innovative and well-led. The manager of outpatients told us that they were committed to continuing to make improvements to the department. This included plans to enable patients to have their pre-assessment on the same day as their outpatient appointment.
- Staff knew the values of the organisation and spoke of the 'Ramsay Way'. They said these values were reflected in people working in the hospital and staff told us they were very patient-focused.

Governance, risk management and quality measurement for this core service

- See the Surgery section for main findings.
- The risk register was held at hospital level. The managers of outpatients and diagnostic imaging were

aware of current risks to their departments and there were plans in place to address these. The manager of outpatients told us about her involvement in developing a new SOP for the department that would help reduce risks.

- Staff were made aware of risks in their particular department. Staff told us they were kept informed of any risks in the department on a daily basis or when anything changed.
- The managers of outpatients and diagnostic imaging attended a daily safety huddle where any risks arising for that day in their departments were discussed with other heads of departments.

Leadership / culture of service

- See the Surgery section for main findings.
- Staff felt that they were well-led by the manager of outpatients and were encouraged with their continual personal development. Staff felt able to use their own initiative but still felt part of a team.
- Staff in the radiology department felt that they had been ‘listened to’ by the general manager when they had asked for more radiologists and this had been addressed.
- Staff liked working in outpatients and radiology because they felt they had the time to give appropriate care and support to patients.

Public and staff engagement

- See the Surgery section for main findings.

Innovation, improvement and sustainability

- The outpatients department was included in the hospital’s commitment to continuously improving the quality of the service.
- The outpatients’ manager was committed to welcoming new ideas and had implemented some changes which had improved the way the department worked. This included a change to the management of wound care that had improved early detection of wound infections, and developing an audit specifically aimed at outpatient department.
- The outpatients’ manager had also participated in the development of a new SOP for outpatient departments.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are trained to a level that is relevant for their role in theatres or further training must be provided.
- The provider must ensure that surgical safety procedures are consistently carried out in theatre and theatre documentation and observational audits are routinely carried out.
- The provider must ensure recovery staff are suitably trained to as per the national guidance.
- The provider must ensure that controlled drugs are destroyed appropriately.

Action the provider SHOULD take to improve

- The provider should ensure that bare below the elbow dress code is adhered to at all times.
- The provider should ensure that all staff receive mandatory training that is relevant and at a suitable level for their role.
- The provider should ensure that the protocol for pre-operative fasting of patients is revisited.
- The provider should ensure that all staff receive an annual appraisal.

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
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** People who use services and others were not protected against potential risk as the provider was not doing all that was reasonably practical to mitigate risks. Surgical safety procedures were not being consistently carried out and observational audits were not being carried out to provide assurance.

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** People who use services and others were not protected against potential risk as the provider had not ensured that there were sufficient numbers of staff who had received the appropriate training as necessary to enable them to carry out the duties of the Surgical First Assistant role in theatres.