Woodthorpe Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Woodthorpe Hospital is an independent health care hospital, based in north Nottingham, which provides services for assessment, diagnosis and treatment of common medical conditions and, is part of Ramsay Health Care UK Operations Limited.

The hospital provides outpatient, inpatient and day case care and treatment for adults 18 years and over for NHS, self-funding and insured patients. Treatments available at the hospital include gastroscopy, flexible sigmoidoscopy, colonoscopy, ear nose and throat (ENT), general surgery, gynaecology, ophthalmology, orthopaedic surgery, podiatric surgery, spinal surgery, urology, vascular and, cosmetic surgery.

Woodthorpe Hospital is registered to provide the following Regulated Activities:

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

The hospital's senior management team consists of a registered manager, quality improvement manager and matron.

We inspected the hospital on 23 and 24 February 2016 on an announced visit. On 2 March 2016 we carried out an unannounced inspection of the hospital.

We inspected surgery, and outpatients and diagnostic imaging at Woodthorpe Hospital. Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections. This inspection was also part of a pilot programme testing how we assess the Workforce Race Equality Standard (February 2016). The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers and independent acute providers that deliver £200k or more of NHS-funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.

Overall, Woodthorpe Hospital was rated as good. We found both surgery services and outpatients and diagnostic imaging services were good in all of the five domains we inspected; safe, effective, caring, responsive and well-led. Outpatients and diagnostic imaging services were good in the four domains we inspected; safe, caring, responsive and well-led.

Are services safe at this hospital

We found services at the hospital were safe. Patients were protected from avoidable harm and abuse:

- There was an open and honest culture at all levels within the hospital. Staff were aware of Duty of Candour regulations and the requirements for them to discuss incidents, where patients had been harmed, in an open, honest and timely way with patients, providing explanations and apologies where required.
- Safeguarding was given sufficient priority. Staff had an understanding of how to protect patients from abuse. Staff could describe what safeguarding was and the process to refer concerns. The hospital had a safeguarding lead; staff knew the name of the safeguarding lead and told us they could approach them for advice if they needed to.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and were fully supported to do so.
- Processes and agreements were in place to transfer patients to an alternative acute hospital if their condition deteriorated.

Summary of findings

- Staffing levels and skill mix were planned, implemented and reviewed to keep patient's safe at all times. A Resident Medical Officer (RMO) provided 24-hour medical and surgical cover for all patients.
- There were systems, processes and standard operating procedures to support effective handover between the RMO, consultants and other clinical staff. They were reliable and appropriate to keep patients safe.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
- However, clinical areas throughout the hospital were carpeted. This is against advice from HBN 00-09 Infection control in the built environment, which states in clinical areas where spillages are anticipated (including patient rooms, corridors and entrances) carpets should not be used. It was noted during our inspection, that minimal invasive procedures were carried out in areas where carpets were present this minimised the risk of any spillage. There were robust procedures in place to ensure carpets were cleaned and, a process in place to remove and replace sections of carpet if they became contaminated. We saw emails detailing procurement plans for replacing carpets with vinyl flooring but were not made aware of a timescale for completion.
- Performance showed a good track record in safety with harm-free care for pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE). There had been no Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Difficile) infections in the year preceding our inspection.

Are services effective at this hospital

We found services at the hospital were effective:

- Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Local policies and procedures and National Institute for Health and Care Excellence (NICE) guidelines were discussed at clinical meetings and through the hospital medical advisory committee.
- Patient outcomes were good with low numbers of readmissions, unplanned transfers of care and, unplanned returns to the operating theatre. Patient reported outcome measures were within the expected range and the England average.
- Endoscopy services were delivered in line with the British Society of Gastroenterology guidance. The endoscopy services had recently achieved Joint Advisory Group on Gastro-intestinal Endoscopy (JAG) accreditation.
- The hospital participated in a number of national audits, for example Patient Recorded Outcome Measures (PROMS), the National Joint Registry (NJR) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). An internal audit programme included theatre audits, consent, patient records and medication.
- Patients had a comprehensive assessment of their needs, which included consideration of pain, nutrition and hydration needs.
- There was a system to ensure qualified doctors, nurses' and allied health professionals (AHPS) registration status had been renewed on an annual basis.
- There were 136 consultants granted practicing privileges at the hospital. Arrangements for granting and reviewing practising privileges were appropriate and staff were competent and skilled to carry out the care and treatment they provided.

Summary of findings

- All staff including black and minority ethnic (BME) staff reported adequate support for continuous professional development in their roles.
- Consent to care and treatment was obtained in line with legislation and guidance including; where 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were made. However, DNACPR decisions were not always reviewed in a timely way upon admission to the hospital.

Are services caring at this hospital

We found services at the hospital were caring:

- Feedback from patients and those close to them was consistently positive about the way they were treated by staff at this hospital.
- Staff treated patients in a respectful, kind and professional manner, maintaining their privacy and dignity at all times.
- Patients and their relatives were pleased with the standard of care they received. The friends and family test (FFT) results were consistently high with between 97% and 100% of NHS patients recommending this hospital to their family and friends.
- Staff helped patients and those close to them to cope emotionally with their care. We saw staff providing reassurance for patients who were anxious and, actively approaching patients after their appointments to make sure that they had no concerns following their consultations.

Are services responsive at this hospital

We found services at the hospital were responsive:

- Services were planned and delivered in a way, which met the needs of the local population and individuals. The importance of flexibility, choice and continuity of care was reflected in the services.
- The needs of different patients were taken into account when planning and delivering services and, the admission process and care provided was the same for self-funded patients and NHS patients.
- The service specification for the community nursing beds and the patients in those beds did not always match; therefore, there was a risk the hospital and the associated environment may not be able to meet the needs of patients outside of the specification.
- The environment on ward two, a ward caring for patients living with dementia was not dementia friendly this meant the full needs of patients living with dementia might not be met.
- Waiting times, delays and cancellations were minimal and managed appropriately. Referral to treatment (RTT) times for both admitted and non-admitted patients were consistently above the national target of 90%. However, waiting times for patients once they had arrived in the outpatient department and cancellation rates of clinics were not routinely monitored.
- The hospital had a policy, which outlined the inclusion and exclusion criteria for patients. Patients with an American Society of Anaesthesiologists (ASA) physical status score of four or greater were excluded.
- It was easy for patients to raise a concern. Complaints and concerns were always listened to taken seriously and responded to in a timely way. Process and systems were in place to agree lessons learned and for sharing of these to ensure improvements were made to care.

Are services well led at this hospital

We found services at the hospital were well led:

Summary of findings

- There was a clear statement of vision and values, driven by quality and safety. The hospital had adopted the corporate Ramsay mission known as the "Ramsay Way" this was a culture which recognised patients, staff and doctors were the company's most important asset and this was said to be key to the organisation's ongoing success.
- The hospital staff had developed the 'Woodthorpe' acronym to underpin the hospital strategy. The values were based on what staff aspired to and included 'W' Welcoming, 'D' Dedicated to providing an excellent quality service and, 'R' responsive to the needs of the patient.
- There was a clear governance structure in place with committees such as clinical governance, senior management and heads of department feeding into the medical advisory committee and hospital management team.
- The hospital senior management team and departmental leaders had the experience, capacity and capability to lead services and prioritised safe, high quality compassionate care. Staff felt there was a culture of openness within the hospital and, described immediate managers and members of the senior team as having adopted an 'open door' policy.
- Staff were passionate about patient care. Staff enjoyed working at the hospital, thought it was a happy environment and found their work rewarding. Staff described an open and transparent culture in the hospital where patients were put first. However, there was mixed staff feedback in relation to the hospital taking an interest in the welfare of staff. The staff satisfaction score for the year 2014/2015 was in line with the Ramsay average.
- Senior managers had the capacity, capability, and experience to lead effectively. There were suitable processes in place to check senior managers were of good character, physically and mentally fit, had the necessary qualifications, skills and experience for the role, and had supplied certain information, this included a disclosure and barring service (DBS) check and a full employment history.
- There was no local strategy in place to address the Workforce Race Equality Standard (WRES) requirements. However, black and minority ethnic (BME) staff all reported no concerns and felt they were supported by managers and generally were happy working at this hospital.

Our key findings were as follows:

- Staff morale and motivation were high and staff enjoyed working at the Woodthorpe Hospital. There was supportive management at all levels, effective team-working and an open culture in which staff were able to raise concerns and make suggestions.
- The Woodthorpe Hospital maintained high standards of cleanliness and hygiene. Patient-led assessments of the care environment (PLACE) for 2015 scored above the national average at 100%. There had been no incidents of healthcare acquired infections in the last 15 months and low numbers of surgical site infections. There were sufficient supplies of personal protective equipment available such as gloves and aprons. We saw staff using these and changing them between patients. The cleaning of equipment was monitored effectively.
- Staffing levels in surgery were calculated, using guidance created from the National Institute for Health and Care Excellence (NICE) Safe Staffing Recommendations (July 2014). These were checked and adjusted daily as required depending on changes and or patient requirements. Throughout the hospital usage of agency nurses was minimal. Wherever possible the hospital used regular bank and agency staff. Vacancy rates in outpatient were high as a percentage (33%) however, this equated to less than one whole time equivalent and, there was active ongoing recruitment in the department.
- A Resident Medical Officer (RMO) provided 24-hour medical and surgical cover for all patients. Consultants and anaesthetists could be contacted 24 hours a day and could return to the hospital within 30 minutes.

Summary of findings

- There had been no unexpected inpatient deaths in the hospital in the 12 months preceding our inspection. If deaths did occur then these would be reviewed and discussed at the clinical governance and Medical Advisory Committee (MAC) meetings.
- Pre admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery and staff checks were made to ensure patients had adhered to fasting times before surgery went ahead. Patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using a recognised tool. After surgery there were accurate and complete records to monitor fluid intake and output with protocols in place to prevent post-operative urinary and kidney dysfunction
- Most patients commented positively on the choice of food available. The hospital provided three meals a day for in-patients. Choices could be seen on the menus and included choices for those on special diets. The hospital had recently introduced

We saw several areas of outstanding practice including:

- There was a rolling programme in the hospital for staff to attend a "Mental First Aid" course. Mental health first aid is an educational course, which teaches people how to identify, understand and help a person who may be developing a mental health issue.
- An '11.15 stand-up huddle' was held daily with senior managers and matrons of the service. This allowed for a joint approach to addressing issues and concerns within the departments. During the meeting, levels of accountability were clearly defined with individuals taking responsibility for issues within their own clinical areas.
- The hospital arranged bi-monthly infection control meetings with links to microbiologists at a local NHS trust. This was a proactive group with representation from all departments to ensure each part of the patient's pathway was safeguarded against the risks of infections.
- Patients were asked about smoking and alcohol consumption as part of their pre-operative assessment. All identified smokers and patients who were deemed to be at risk of alcohol related complications were given advice leaflets.
- A target controlled infusion (TCI) system was used in theatres for the administration of anaesthetics. TCI avoids over dosage of a patient with anaesthesia and allows the anaesthetist to adjust the levels of drug administered according to patient need.
- The hospital promoted a 'policy of the week'; to encourage staff to familiarise themselves with a different policy each week.
- The hospital was undertaking a locally developed (CQUIN) in 2015/16. This involved improving patient experience in endoscopy through recording all patients' experience of their endoscopy using the Gloucester comfort score.
- The department leader for the Post Anaesthetic Extended Care Unit (PAECU) had forged links with the local critical care network which had allowed all of the nursing staff on the ward to be trained for critical care transfers from the hospital should they be required.
- The physiotherapy department had introduced a physiotherapy joint school. The joint school was a three-day care pathway for patients who had undergone joint surgeries for example knee replacement. As a result of the joint school there had been a reduction in readmission of joint patients.
- The physiotherapists told us that if they had a patient who did not attend (DNA) an appointment, they would call to check the patient was safe and to rebook the appointment.

However, there were also areas of poor practice where the hospital needs to make improvements.

Summary of findings

The hospital should:

- The hospital should ensure that they comply with reporting requirements for the Workforce Race Equality Standard.
- The hospital should ensure all medicines on the resuscitation trolleys are in date and ready for use.
- The hospital should ensure medicines trolleys are stored in line with hospital policy, current legislation and best practice guidance.
- The hospital should ensure there are processes in place to assess, monitor and improve the quality of services in the outpatients department including the monitoring of cancellations and delays.
- The hospital should ensure flooring in clinical areas is compliant with HBN 00-09 infection control in the built environment.
- The hospital should ensure medicine prescription pads are stored in a locked cabinet within a lockable room or area locked room in line with NHS guidance (2013).
- The hospital should ensure there is an improvement in mandatory training rates.
- The hospital should consider reviewing the process for admission to the community nursing beds to ensure that the patients admitted to the hospital meet the service specification for the community nursing beds.
- The hospital should consider reviewing the environment on ward two to make it dementia friendly.
- The hospital should consider equipping theatre four with all of the standard equipment associated with a theatre for example piped oxygen and suction units in line with HBN 26 Facilities for surgical procedures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Overall, we rated surgical services at Woodthorpe Hospital as good. Patients were protected from avoidable harm and abuse. Systems, processes and standard operating procedures in infection control, patient records and the monitoring, assessing and responding to risk were reliable and appropriate to keep patients safe. There were clearly defined and embedded systems and procedures to keep patients safeguarded from abuse. However, on ward one we found a medicines trolley left unlocked. Patients' care and treatment was planned and delivered in line with current evidence based guidance, however, whilst there was a process in place to ensure 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were reviewed in a timely manner this had not always been followed. Patients were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients who used the hospital and those close to them was positive about the way staff treated them. Patients' needs were met through the way services were organised and delivered. Services were planned and delivered in a way, which met the needs of the local population and individuals. However, the service specification for the community nursing beds and the patients in those beds did not always match; therefore, there was a risk the hospital and the associated environment may not be able to meet the needs of patients outside of the specification. The leadership of the service was good. The leadership, governance and culture promoted the delivery of high quality person-centred care. There was a clear statement of vision and values, driven by quality and safety. Departmental leaders had the experience, to lead the services and prioritised safe, high quality compassionate care. However, service developments were not always developed or assessed with input from appropriate members of the clinical team and as such, there was not always an understanding of the impact on the quality of care as a result of the developments. There was mixed staff

Summary of findings

feedback in relation to the hospital taking an interest in the welfare of staff. The hospital was not delivering on the requirements of the Workforce Race Equality standard (WRES).

Outpatients and diagnostic imaging

Good 

Patients were protected from abuse and avoidable harm. Staff we spoke with understood their responsibilities to raise concerns and report incidents. They understood their safeguarding responsibilities and demonstrated an understanding around consent and the Mental Capacity Act (MCA) 2005. Patient risks were assessed and steps taken to minimise these risks. Medicines and records were stored securely.
Care reflected national guidance, and staff received training to be competent in their role. The diagnostic and imaging department participated in the hospital audit schedule. There was good multi-disciplinary working and effective working relationships throughout the department and the rest of the hospital.
Staff treated patients in a respectful, kind and professional manner, maintaining their privacy and dignity at all times. Patients and their relatives were pleased with the standard of care they received. The friends and family test (FFT) results for January 2016 reported that 99% of the NHS patients would recommend the outpatients and diagnostic and imaging department to their family and friends. However, response rates to the friend and family test (FFT) were low (7%).
Services were designed to meet the needs of the population and all patients were seen within 18 weeks of referral to the hospital.
There was a clear vison and strategy for the service. There were clear lines of accountability in the outpatients and diagnostic imaging department. Staff spoke positively about their line managers.
Effective governance systems were in place and lessons were learnt and changes in practices resulted in response to complaints.
There was however, nursing vacancies within the outpatients department, although active recruitment was ongoing. In addition, not all staff within the outpatients department had completed their mandatory training.
The environment within the department was not compliant with HBN 00-09. There were hand operated

Summary of findings

taps and carpeted floor in the consulting rooms. However, the hospital had plans to address this. A small number of staff were not seen to adhere to the bare below the elbow policy.
There was not monitoring of waiting times for patients once they have arrived in the department or cancellation rates of clinics.

Summary of findings

Contents

Good

Woodthorpe Hospital

Services we looked at

Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to Woodthorpe Hospital

The site on which Woodthorpe Hospital stands has been delivering healthcare to the people of Nottingham and surrounding areas since 1877. The hospital was formerly owned by a locally respected religious order and known as The Convent Hospital. Ownership was transferred a further two times before final ownership transferred to Ramsay Healthcare UK (now known as Ramsay Health Care UK Operations Limited) on 1 April 2008 and the hospital became known as Woodthorpe Hospital.

The hospital has a registered manager, registered on 4 January 2016 and, Controlled Drugs Accountable Officer, registered on 19 May 2015.

The hospital provides outpatient, inpatient and day case care and treatment for adults 18 years and over for NHS, self-funding and insured patients.

The hospital facilities include 38 individual patient rooms across two wards and, a two-bedded Post Anaesthetic Extended Care Unit (PAECU) for patients requiring a higher level of observation post operatively, four operating theatres, including a recovery area for patients recovering immediately post-surgery. A pharmacy is also provided on site.

The outpatient department incorporates 10 consultation rooms where services are offered up to six days a week Monday to Sunday 8am to 8pm, one treatment room, two dedicated preoperative assessment rooms and a private patient lounge.

The physiotherapy department has an integrated gymnasium.

The imaging department provides facilities for both static and mobile on site plain film X-Ray, fluoroscopy and ultrasound, with provision for magnetic resonance imaging (MRI) and computed tomography (CT) on visiting mobile scanners.

Treatments available at the hospital include gastroscopy, flexible sigmoidoscopy, colonoscopy, ear nose and throat (ENT), general surgery, gynaecology, ophthalmology, orthopaedic surgery, podiatric surgery, spinal surgery, urology, vascular and, cosmetic surgery.

We inspected surgery and outpatients and diagnostic imaging at Woodthorpe Hospital. For the purpose of this inspection the 14 community nursing beds and endoscopy was inspected as part of surgery. Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections. This inspection was also part of a pilot programme testing how we assess the Workforce Race Equality Standard (February 2016).

Our inspection team

Our inspection team was led by:

Inspection Lead: Michelle Dunna, Inspector, Care Quality Commission.

The team included CQC inspectors, an assistant inspector and a variety of specialists including Equality and Diversity Manager, a Consultant Anaesthetist, a Colorectal Surgeon and an Outpatients Manager who was also a registered nurse.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Summary of this inspection

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we hold about Woodthorpe Hospital and sought the views of the clinical commissioning group (CCG). We carried out an announced visit between 23 and 24 February 2016. During the visit we talked with staff and people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. The people who use services shared their views and experiences of the hospital with us. We carried out an unannounced visit on 2 March 2016.

We spoke with 60 staff including; registered nurses, physiotherapists, radiographers, health care assistants, administration and reception staff, medical staff including consultants, operating department practitioners, porters and senior managers. We also held a mixed staff focus group with 18 members of hospital staff and interviewed the senior management team.

For surgery, we spoke with 10 patients and four relatives / friends. For outpatients and diagnostic imaging, we spoke with seven patients and two relatives. We also received 15 'tell us about your care' comment cards which patients had completed prior to our inspection.

During our inspection we reviewed 14 sets of patient notes.

Information about Woodthorpe Hospital

The site on which Woodthorpe Hospital stands has been delivering healthcare to the people of Nottingham and surrounding areas since 1877. Current ownership of Woodthorpe Hospital transferred to Ramsay Healthcare UK (now known as Ramsay Health Care UK Operations Limited) on 1 April 2008.

In the reporting period October 2014 to September 2015 there were 5,197 procedures carried out in the operating theatres and endoscopy. The five most common procedures performed were diagnostic gastroscopy (744), diagnostic colonoscopy (380), total prosthetic knee replacement (364), phacoemulsification (337) and primary total hip replacement (280).

Between October 2014 and September 2015, there was a total of 1,708 inpatient (overnight) episodes of care. Of this number, 277 were self-funding patients. Day case activity accounted for 4,093 episodes. Of this number, 725 were self-funding patients.

Between October 2014 and September 2015, a total of 11,619 outpatients were seen for a first visit and 13,534 outpatients were seen for a follow-up visit. Of the total numbers of outpatients 7,913 NHS outpatients were seen for a first visit and 8,964 NHS outpatients were seen for follow up visits at the hospital.

In the same time period, 3,706 non-NHS patients were seen for a first visit and 4,570 non-NHS patients were seen for a follow-up visit.

Community nursing beds were available for those patients transferred from nearby acute NHS trusts who were awaiting transfer to alternative care facilities. Between October 2014 and September 2015 community nursing beds accounted for 327 patients, this totalled 1,944 bed days.

The hospital has 136 doctors and dentists working under rules or privileges and, employs 199.4 whole time equivalent (WTE) staff. Employed staff includes; nurses, operating department practitioners, care assistants, allied health professionals, administrative and clerical staff and, other support staff.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Good

Surgery

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

Information about the service

Surgical services at Woodthorpe hospital provide day and overnight facilities for adults undergoing a variety of procedures. The majority of patients attending the hospital for surgery are NHS funded.

Facilities at Woodthorpe hospital include 38 individual patient rooms over two wards, ward one and ward two in addition to a two-bedded Post Anaesthetic Extended Care Unit (PAECU) for patients requiring a higher level of observation post operatively. The hospital has four operating theatres including a recovery area for patients recovering immediately post-surgery and a treatment room in the outpatients department used for minor procedures. One operating theatre hosted the endoscopy suite. Ward two is commissioned to provide a flexible number of community nursing beds to a neighbouring trust; these are used for patients awaiting transfer to alternative care facilities such as care homes.

In the reporting period October 2014 to September 2015 there were 5,197 procedures carried out in the operating theatres and endoscopy. The five most common procedures performed were diagnostic gastroscopy (744), diagnostic colonoscopy (380), total prosthetic knee replacement (364), phacoemulsification (337) and primary total hip replacement (280).

In the same reporting period the hospital cared for 327 patients in the community nursing beds on ward two who were awaiting transfer to alternative care facilities, this totalled 1944 bed days. In the reporting period October 2014 to September 2015 there were 668 level one PAECU bed days available of these 49 bed days were utilised.

Sterile services are based on site at the hospital. This ensures reusable equipment is cleaned, sterilised and packed for further use and returned to theatres.

During our inspection, we visited wards one and two, PAECU, operating theatres including endoscopy and recovery area. The pre-operative assessment clinic and sterile services department. We observed the care of patients on the wards and recovery area and during operative procedures in theatre. We spoke with 10 patients, four relatives / friends, 33 staff including nurses, medical staff including consultants, operating department practitioners, therapy, supporting staff, porters and senior managers. We also received 15 ‘tell us about your care’ comment cards which patients had completed prior to our inspection. Before our inspection, we reviewed performance information from and about the hospital.

Good

Surgery

Summary of findings

The safety of this service was good. Patients were protected from avoidable harm and abuse. Systems, processes and standard operating procedures in infection control, patient records and the monitoring, assessing and responding to risk were reliable and appropriate to keep patients safe. There were clearly defined and embedded systems and procedures to keep patients safeguarded from abuse. However, on ward one we found a medicines trolley left unlocked.

The effectiveness of this service was good. Patients using the service were receiving effective care and treatment, which met their needs. Patients' care and treatment was planned and delivered in line with current evidence based guidance, however, whilst there was a process in place to ensure 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were reviewed in a timely manner, this was not always followed. This may leave patients at risk of receiving inappropriate or unwanted attempts at CPR.

The care provided to patients was good. Patients were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients who used the hospital and those close to them was positive about the way staff treated them.

The responsiveness of the service was good. Patients' needs were met through the way services were organised and delivered. Services were planned and delivered in a way, which met the needs of the local population and individuals. However, the service specification for the community nursing beds and the patients in those beds did not always match; therefore, there was a risk the hospital and the associated environment may not be able to meet the needs of patients outside of the specification. The environment on ward two was not dementia friendly.

The leadership of the service was good. The leadership, governance and culture promoted the delivery of high quality person-centred care. There was a clear statement of vision and values, driven by quality and safety. Departmental leaders had the experience to lead the services and prioritised safe, high quality compassionate care. However, service developments were not always developed or assessed with input from appropriate members of the clinical team and as such, there was not always an understanding of the impact on the quality of care as a result of the developments. There was mixed staff feedback in relation to the hospital taking an interest in the welfare of staff. The hospital was not compliant with its equality duties and was not able to deliver on the requirements of the Workforce Race Equality standard (WRES).

Good

Surgery

Are surgery services safe?

Good

The safety of this service was good. Patients were protected from avoidable harm and abuse. We found;

- Openness and transparency about safety was encouraged.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Performance showed a good track record in safety for example there were no infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Difficile).
- Systems, processes and standard operating procedures in infection control, patient records and, the monitoring, assessing and responding to risk were reliable and appropriate to keep patients safe.
- There were clearly defined and embedded systems and procedures to keep patients safeguarded from abuse. Staff knew the signs of abuse and had access to appropriate resources.

However we found;

- We found an unattended medicines trolley on ward one that was not secured to the wall.

Incidents

- Staff we spoke with knew, and appeared knowledgeable and confident about reporting incidents. Permanent and bank staff had access to the online reporting system. We spoke with one agency member of staff and one bank member of staff they told us they did not have access to the computer system to report incidents, however they told us they would report incidents to the nurse in charge. Staff gave us examples of when they might report incidents such as falls, medication errors and infections. Staff said there was no blame culture in the service and they felt able to report incidents without fear of reprisal.
- Staff told us they did not always receive individual feedback for incidents they reported, however incidents giving cause for concern or following a specific trend were discussed in the ward meetings. We saw evidence of this in the ward meeting minutes.
- There were 169 clinical incidents within the reporting period January 2015 to December 2015. The rate of clinical incidents (per 100 inpatient discharges) had fallen sharply in the reporting period. Of the 169 clinical incidents, two were serious incidents (SI). Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response (NHS England, March 2015). Root cause analysis was undertaken for all SI and where lessons were to be learned actions were created and completed. Root cause analysis findings were shared with staff during staff meetings, minutes from meetings confirmed this,
- There was an effective system in place for the distribution of alerts from the central alerting system in relation to medical equipment. Staff told us about a recent alert they had actioned.
- The regulation Duty of Candour states providers should be open and transparent with people who use services; it sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. We reviewed an incident where duty of candour had been carried out. Staff we spoke with whilst not familiar with the terminology “duty of candour” knew their responsibilities to be open and honest with patients when things did go wrong and offered an apology.
- There had been no deaths in the hospital in the 12 months preceding our inspection. If deaths did occur then these would be reviewed and discussed at the clinical governance and Medical Advisory Committee (MAC) meetings. This meant any lessons to be learned would be highlighted.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and ‘harm free’ care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Safety thermometer results for the period October 2015 to December 2015 showed care was harm free.

- The VTE screening target of 95% for all patients was consistently achieved in the reporting period October 2014 and September 2015; 95% is the targeted rate for NHS patients.
- There was one patient who had a hospital acquired VTE or pulmonary embolus (PE) in the period between October 2014 to September 2015. A PE is a blockage of an artery in the lungs. The most common cause of the blockage is a blood clot.
- Safety thermometer information was displayed in the clinical areas. This meant staff, patients and visitors were able to see the results and any trends in this data.

Cleanliness, infection control and hygiene

- In the 2015, Patient-led assessments of the care environment (PLACE) the hospital scored 100% for cleanliness. This was above the national average of 98%.
- The wards, theatres and recovery areas were visibly clean and tidy. This included not just the clinical areas but also the corridor, bathrooms, offices and storage rooms.
- All patient's bedrooms and corridors were carpeted with short pile carpet these were visibly clean and free from stains. HBN 00-09 Infection control in the built environment states in clinical areas where spillages are anticipated (including patient rooms, corridors and entrances) carpets should not be used in these areas. It was noted during our inspection, that minimal invasive procedures were carried out in areas where carpets were present this minimised the risk of any spillage. Department leaders told us and we saw evidence that carpets were cleaned after each patient use. There was a process in place to remove and replace sections of carpet if they became contaminated. There was a plan in place to replace the carpets in the clinical areas with vinyl flooring in order to comply with HBN 00-09. We saw emails detailing procurement plans for vinyl flooring but were not made aware of a timescale for completion.
- The hospital had reported no incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C Difficile) or Methicillin-sensitive Staphylococcus Aureus (MSSA) in the reporting period between October 2014 and February 2016. MRSA, MSSA and C.Difficile are all infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.Difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics.
- There were a low number of surgical site infections, three following 5,197 surgical procedures, in the reporting period July 2014 to February 2016. This was less than one percent of operations resulting in surgical site infections.
- Hand hygiene audit results for September 2015 showed an average compliance of 100% and for December 2015 96 % compliance with effective hand washing. Action plans were in place to address the areas where 100% compliance was not achieved.
- Two of the four operating theatres had higher levels of air filtration (laminar flow). This was particularly important for joint surgery to reduce the risk of infection. We saw evidence the filtration system were regularly maintained, cleaned and tested.
- An infection prevention programme ensured management and monitoring of infection control took place throughout the wards and theatre. We saw staff following good practice guidelines for infection prevention and control, for example the use of gloves and aprons. This minimised the risk of infection to patients.
- Cleansing gel was available at the entrances to each area and in each room; patients and visitors were encouraged to use it by staff and. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively. We observed staff and patients using the cleansing gel in line with the information provided.
- Staff were 'bare below the elbow' to allow effective hand washing.
- Protective equipment, such as gloves and aprons, were available and we observed staff washing their hands between patients.
- With the exception of the Post Anaesthetic Extended Care Unit (PAECU) all patient were treated in individual rooms. This reduced the risk of the spread of infection.
- We saw staff adhering to procedures in line with national guidance to minimise the risk of infection to patients undergoing surgical procedures, for example, skin preparation and the use of sterile drapes.

- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. This minimised the infection risk.
- When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk.
- Changing into surgical scrubs and theatre caps was a requirement of all staff and visitors to theatre. Our observations during inspection confirmed that this was adhered too.
- There was a system for ensuring equipment was clean, for example 'I am clean' stickers. These were clearly visible, dated and signed to indicate cleaning had taken place. We observed patient-care equipment to be clean and ready for use.
- We saw evidence deep cleaning in theatres took place twice per year; this is considered good infection prevention control practice.
- MRSA screening was carried out on all patients who were admitted as part of the community nursing beds pathway. Select patient groups attending for surgical procedures, such as patients having knee and hip surgery were screened for MRSA as part of their pre-operative assessment. This was in line with the hospital policy.
- The hospital arranged bi-monthly infection control meetings with links to microbiologists at a local NHS trust. This was a proactive group with representation from all departments to ensure each part of the patient's pathway was safeguarded against the risks of infections.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and environmental cleanliness.

Environment and equipment

- Access to theatres was through a swipe card system. This meant the area was secure and minimised the risk of unauthorised access.
- Staff had signed to indicate the resuscitation equipment on most of the wards and in theatres had been checked daily and was safe and ready for use in an emergency. Single-use items were sealed and in date, and emergency equipment had been serviced. However, we found five vials of out of date medication in the resuscitation trolley on ward two, we escalated this to the ward manager who arranged for this to be replaced immediately.
- Staff had signed to indicate the emergency / difficult intubation equipment in theatre had been checked daily and was safe and ready for use in an emergency. Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway.
- An operating department practitioner (ODP) and anaesthetist checked the anaesthetic machines and equipment daily in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. Anaesthetic machines and equipment were in working order and safe to use.
- An onsite department provided sterile services and supplies. Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if required.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements.
- Equipment was available in theatres for overweight patients, for example a larger operating table.
- Registers of implants, for example hips and knees, were kept by theatres; these ensured details could be quickly provided to the health care product regulator if required.
- Fire-fighting equipment had been maintained and tested.
- There was an effective arrangement for a third party company to service and maintain all medical equipment such as vital sign machines.
- Random checks of 11 pieces of equipment across theatres and the wards showed equipment had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service and routine servicing. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Theatre four did not have all of the standard equipment associated with a theatre for example piped oxygen and suction units. HBN 26 Facilities for surgical procedures state not all operating theatres need to be fully equipped for minimal invasive surgery; however, it is recommended all the medical services be installed from

the outset so every theatre can be reconfigured in the future. We were told procedures were not routinely carried out in this theatre however, we saw the theatre had been used in September 2015 for six procedures, January 2016 for three procedures and February 2016 for four procedures all procedures were minimally invasive and were carried out under local anaesthetic. The hospital told us provision would be made to ensure the required equipment was available in theatre four when a list was being carried out. In the long term, the hospital intended to renovate the theatre for it to be used on a permanent basis.

Medicines

- We found that the pharmacy manager provided a comprehensive clinical service to ensure patients were safe from harm. The pharmacy manager visited all wards each week day, Monday to Friday. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. Administration of medication was recorded on a comprehensive prescription chart.
- We looked at the prescription and medicine administration records for ten patients on the wards and theatre. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.
- Medicines on the wards and in theatre, including controlled drugs and those requiring cool storage, were stored appropriately, however on ward one we found a drug trolley was not secured to the wall. We discussed this with the department leader who said a new cable had been ordered as the previous one had broken. We did not see any actions in place to address the risk of the trolley being removed by an unauthorised person. On our unannounced visit a week later, we saw that the trolley was not secured to the wall. We escalated this to the hospital manager who assured us that the hospital maintenance team would secure this immediately.
- We saw records of daily checks of the fridge temperatures and controlled drugs had been completed and were up to date. We took the opportunity to check the stock levels of controlled drugs with the controlled drugs register and they tallied correctly. Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register.
- There were local microbiology protocols in place for the administration of antibiotics. Doctors we spoke with demonstrated an awareness of these. Antibiotics on the drug cards we reviewed had a review and or completion date. This is considered good practice.
- Staff in the hospital completed an annual drugs calculation assessment and had additional training in the administration of intravenous drugs.

Records

- We reviewed ten sets of nursing and medical records. Records were paper-based. Nursing records were stored in the patient's room. Medical notes were stored securely in locked trolleys in the main ward office.
- Patient records were multidisciplinary and we saw where nurses, doctors and allied health professionals including physiotherapists had made entries.
- Records were legible, accurately completed and up to date.
- Integrated care records for day case surgery and long stay surgery were in use. These covered the entire patient pathway from pre-operative assessment to discharge; they included comprehensive care plans for identified care needs.
- Patients receiving care in the community nursing beds had a comprehensive admission document completed and necessary care plans put in place for example nutrition and pressure area care.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.

Safeguarding

- There was a safeguarding adult at risk of abuse or neglect policy and procedure, which included guidance on safeguarding adults.
- Two department leaders and matron were the lead for safeguarding of adults.
- A safeguarding resource folder was available on the ward, this included flow charts to assist staff in the safeguarding process and contact numbers for the local authority safeguarding team.

- Four out of five staff we spoke to demonstrated an awareness of potential safeguarding issues and procedures to follow for suspected or alleged abuse. All staff could tell us whom the safeguarding lead was for the hospital, so knew where to seek advice. Staff knew and could show us how to access the safeguarding resource folder.
- Staff received safeguarding of vulnerable adults training as part of their mandatory training programme.

Mandatory training

- Mandatory training for all groups of staff included fire safety, moving and handling, basic life support, infection prevention control and safeguarding.
- Mandatory training data showed approximately 76% of staff in theatres, 83% in endoscopy and 72% on the wards were in date with this training. This was lower than the hospitals target of 100%; however, we noted some staff had recently commenced employment at the hospital and were scheduled to attend mandatory training. The hospital told us their annual plan for 2016 would accommodate any outstanding training.

Assessing and responding to patient risk

- All patients including NHS patients saw their named consultant at each stage of their surgical pathway. Patients in the community nursing beds were cared for daily by the resident medical officer (RMO) in conjunction with their local General Practitioner and designated medical consultant at the hospital.
- Anaesthetists and pre admissions nurses calculated the patient's American Society of Anaesthesiologists (ASA) grade as part of their assessment of a patient about to undergo a general anaesthetic. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels, with level one being the lowest risk. The hospital only undertook procedures for patients graded as levels one to three. The chair of the medical advisory committee (MAC) had the authority to stop a patient's admission to the hospital if they had significant co-morbidities (pre-existing conditions) that would put them at risk. The pre-operative assessment nurse had direct access and contact details for the MAC, so any issues in relation to a patient's condition could be escalated at the pre-operative stage.
- A nurse assessed patients in pre assessment clinics prior to surgery. Any concerns during this assessment for example the patients fitness for surgery would be directed to the anaesthetist and the patients consultant. Any additional input for example if the patient had a specific need whilst on the ward were communicated to the ward and theatre prior to the patient's admission.
- A 'pre list brief' took place in theatres prior to the list starting, this involved discussion for each planned procedure. Notes were made and stored for future reference and could be used if any issues were raised about planning and procedures.
- The Five Steps to Safer Surgery safety checklist was embedded in daily practice and adhered to. This is a process recommended by the National Patient Safety Agency (NPSA) for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors. For each patient's procedure, the checklists were followed and completed in full. We reviewed the sample audits undertaken in theatre, which included a review of the Five Steps to Safer Surgery checklist completion. Results for September 2015 and November 2015 showed the checklist was completed satisfactory in all areas, 100% of the time. Observations during our inspection showed this process was carried out in full during each case
- There was a separate Five Steps to Safer Surgery safety checklist for patients undergoing cataract procedures. This was in line with NPSA guidance.
- Early warning scores (EWS) were used throughout the wards and in theatre recovery to monitor patients and identify when their condition may be deteriorating. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. Within recovery, EWS commenced as the patient woke from their anaesthetic and multiple observations were undertaken before the patient returned to the ward. Staff in recovery recorded a minimum of two EWS score before a patient left recovery to go back to the ward. This meant patients were stable and safe to transfer back to the ward.
- As part of the audit programme, the hospital monitored the escalation of the deteriorating patient to the Resident Medical Officer (RMO). Results for September 2015 showed the care of five out of seven (71%) patients had been escalated in line with the hospital 'Track and Trigger' flow chart, an action plan was in place to

address the 29% shortfall. Results for the recording of vital signs such as blood pressure and pulse and the calculation of a EWS showed 100% compliance. During our inspection, all 10-observation charts we looked at were completed fully in line with the hospital policy. None of the charts we reviewed required the nurse to escalate the patients care in line with the 'Track and Trigger' flow chart.

- There was a hospital policy in place for the emergency management of cardiopulmonary resuscitation this was in line with national guidance.
- Regular simulated cardiac arrest scenarios were carried out so staff could respond quickly and be rehearsed should a real life cardiac arrest occur.
- A resident medical officer (RMO) was available 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient's clinical condition.
- An anaesthetist remained on site at all times when patients were in the recovery room post operatively.
- Processes and agreements were in place to transfer patients to an alternative acute hospital if their condition deteriorated.
- On discharge, patients were given the contact details for the hospital so they could call if they experienced any problems. Staff told us if patients did contact the ward following discharge with problems or for advice they would speak to the Resident Medical Officer (RMO). Advice and conversations were recorded on a medical continuation sheet and filed in the patients notes.
- A supply of blood was available in the hospital for use in an emergency. There was an agreement in place with a neighbouring trust for additional blood should this be required. Patients undergoing specific surgery for example hip and knee replacements were group and saved so they could be crossed matched in a timely way if blood was needed. We saw and staff told us about the major haemorrhage protocol in the event of this occurring. A major haemorrhage is excessive blood loss which can be life threatening.
- There was direct access to a consultant specialising in medicine should this be required, for example a surgical patient requiring review by a medical consultant.

Nursing staffing

- The hospital's ward staffing levels were set using the Ramsay guidance which was based on the National Institute for Health and Care Excellence (NICE) Safe Staffing Recommendations July 2014 - Safe Staffing levels in Adult Inpatient Wards in Acute Hospitals. The ward were currently trialling the use of the Shelford safer nursing care tool. The safer nursing care tool has been developed to help hospital staff measure patient acuity and / or dependency to inform evidence-based decision making on staffing. The tool offers nurses a reliable method against which to deliver evidence-based workforce plans to support existing services.
- Staffing levels were calculated initially on a weekly basis, checked and adjusted daily as required depending on changes and or patient requirements.
- Staffing levels were calculated on a ratio of seven patients to one registered nurse at all times on the surgical ward. Patients requiring a higher level of supervision or one to one nursing care were excluded from the staff to patient ratios and their healthcare needs were assessed on a shift by shift basis and staffing levels adjusted in line with their needs. Staffing levels for the community beds were calculated on a ratio of 15 patients to one registered nurse at all times with support from three non-registered members of staff. It was recognised patients in the community beds required minimal nursing input. Additional staffing could be provided if the patients' needs changed, and we saw additional input provided during our inspection when a patients needs changed.
- Usage of agency nurses was less than 20% for the year October 2014 to September 2015. Wherever possible the hospital used regular bank and agency staff. There was no use of agency for care assistants during this period.
- Department leaders had a minimal patient caseload to allow for unpredictable or unplanned events and so they could support nursing staff where required.
- There was an on call rota for nursing staff should additional support be required during the night or at weekends.
- We saw an agency staff induction checklist on the ward. One agency nurse confirmed and we saw this had been completed prior to them commencing shift.
- Handovers occurred at each shift change and involved all staff on duty for the shift; this meant all staff knew all patients' individual needs. A written record of relevant patient issues was supplied to each staff member on duty.

Surgical staffing

Good

Surgery

- A Resident Medical Officer (RMO), trained in advanced life support, provided 24-hour medical and surgical cover for all patients.
- Consultants and anaesthetists could be contacted 24 hours a day and could return to the hospital within 30 minutes.
- There was an on call rota for theatre staff for the unlikely event of a patient needing to return to theatre.
- Consultants crossed covered each other within the same speciality or sub speciality**.** Consultant's unavailability for example annual leave was covered by consultant colleagues from the same speciality and covered the entire period of absence from the hospital. This was communicated with staff through a rota held by the main administration department. Staff we spoke with were aware of this arrangement.
- There were 136 consultants granted practicing privileges at the hospital. The majority of these worked at local NHS trusts. They included consultants with specialties such as ophthalmology and orthopaedics. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there.
- The theatre staffing rota was planned on a weekly basis and adjusted where necessary according to speciality and case mix.
- The hospital worked within the recommendations of the 'Association for Perioperative Practice' with regard to numbers of staff on duty during a standard operating list. This comprised of two health care assistants, a scrub nurse, operating department practitioner (ODP), a consultant, anaesthetist and a first surgical assistant.
- Usage of agency staff in the theatre department was less than 20%) for the year October 2014 to September 2015.
- Theatre had access to bank surgical first assistants and two substantive members of staff were nearing completion of a course to become surgical first assistants. A further two were in training. A surgical first assistant works closely with the surgeon to facilitate the procedure and process of surgery. They undertake classroom and on the job training before being deemed competent.
- There were systems, processes and standard operating procedures to support effective handover between the RMO, consultants and other clinical staff. They were reliable and appropriate to keep patients safe.

Major incident awareness and training

- Business continuity plans were available on the wards and staff knew how to access these if required.
- Routine fire drills took place, this allowed staff to rehearse their response in the event of a fire.
- Generator testing took place each month and was carried out by the onsite maintenance engineer.

Are surgery services effective?

Good

The effectiveness of this service was good. Patients using the service were receiving effective care and treatment, which met their needs. We found:

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards and best practice legislation. Patient needs were assessed throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards. Day surgery was consistent with the 'British Association of Day Surgery (BADS). Endoscopy services were delivered in line with the British Society of Gastroenterology guidance.
- There was participation in relevant local and national audits and the hospital had received Joint Advisory Group (JAG) accreditation for endoscopy.
- Patient outcomes were positive, consistent and met expectations.
- Staff worked collaboratively to understand and meet the range of patient's needs.
- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions.

However we found;

- Whilst there was a process in place to ensure 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were reviewed in a timely manner, this was not always followed. This may leave patients at risk of receiving inappropriate or unwanted attempts at CPR.

Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as National Institute for Clinical Excellence (NICE) guidelines.
- Care in endoscopy was in line with the British Society of Gastroenterology guidance.

- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of nursing care were based on the use of integrated care pathways such as for orthopaedic surgery. Such care pathways were evidence based and aligned to best practice guidance.
- The delivery of day surgery was consistent with the 'British Association of Day Surgery' (BADS). BADS promotes excellence in day surgery and provides information to patients, relatives, carers, healthcare professionals and members of the association.
- Patients undergoing knee surgery were assessed using the Oxford Scale, which measures muscle strength and range of movement. These assessments were completed pre and post operatively so the rehabilitation progress could be evaluated.
- In line with professional guidance, the hospital had a process in place for the recording and management of medical device implants.
- We saw the hospital participated in a number of national audits, for example Patient Recorded Outcome Measures (PROMS), the National Joint Registry (NJR) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- An internal audit programme included theatre audits, consent and medication; the results were used to inform areas for improvement.
- Medical staff told us NICE guidelines were discussed at clinical meetings; minutes of these meetings reflected this.
- Patient records showed patients had been asked about smoking and alcohol consumption as part of their pre-operative assessment. All identified smokers and patients who were deemed to be at risk of alcohol related complications were given verbal advice and leaflets. This is considered good practice.
- A target controlled infusion (TCI) system was used in theatres for the administration of anaesthetics. TCI avoids over dosage of a patient with anaesthesia and allows the anaesthetist to adjust the levels of drug administered according to patient need. TCI is considered good practice for patients undergoing day surgery.
- During our inspection, we reviewed 14 different policies and procedures these were a mixture of paper and electronic based. We found them all to be up to date this meant patients were receiving evidence based care and following current guidance.

Pain relief

- The hospital used a number of different medicines for relieving pain post-operatively dependent upon the surgery. Information about the medicine prescribed, including how to use it and any side effects was given to patients.
- Information about pain management was given to patients prior to surgery and following their operation. This enabled the patient to communicate effectively with staff and obtain the correct pain relieving medication following their surgery.
- Pain was discussed with patients as part of the pre-operative assessment, and patients with increasing symptoms were offered support with medication to address pain.
- The theatre care pathway ensured staff enquired about patients' pain and adequate pain was relief given in a timely manner. We saw an anaesthetist ensuring patient's pain would be controlled before waking from anaesthetic by administering pain relief. Anticipatory pain relief was prescribed on all drug charts we reviewed.
- We observed staff regularly reviewing pain in the recovery area post-surgery. If a patient had pain, they administered pain relief and checked this had the desired effect.
- Pain assessment scores used on the ward assessed the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief. Nursing records we checked demonstrated staff were identifying the patient's level of pain and evaluating the effects of pain relief on a consistent basis.
- Patients told us staff were quick to respond to pain and would be given pain relief immediately if this was asked for.

Nutrition and hydration

- Patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- There were additional supplements for example energy drinks available for patients who needed a higher calorie intake.

Good

Surgery

- Pre admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Records showed checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- Staff followed best practice guidance on fasting prior to surgery. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- If patient procedures were delayed or the surgery list order changed then anaesthetists indicated to the nursing staff new fasting time for patients. This was documented on a whiteboard in the ward office.
- After surgery, there were accurate and complete records to show fluid intake and output was monitored. We saw and staff told us about protocols in place to prevent post-operative urinary and kidney dysfunction.
- We saw where patients required food charts these were completed with the relevant information and were up to date. Catering staff communicated any concerns in relation to a patients food intake with nursing and care staff
- We saw anaesthetic staff prescribing medication to ensure effective management of nausea and vomiting should this occur. One patient told us they started to vomit following surgery and staff were quick to administer medication to help alleviate this.

Patient outcomes

- The hospital endoscopy service had recently received Joint Advisory Group (JAG) accreditation. JAG Accreditation is the formal recognition an endoscopy service has demonstrated it has the competence to deliver against the measures in the endoscopy standards and ensures quality and safety of patient care when endoscopy is practiced.
- The Joint Advisory Group on gastrointestinal endoscopy (JAG) issued guidance for practitioners to achieve caecal intubation rates of 90 % or above. Caecal intubation rate is an important indicator of colonoscopy quality. The hospital caecal intubation rates were between 92% and 94%. This meant colonoscopies were of good quality. Caecal intubation is the passage of the probe used to obtain pictures within the bowel to the appropriate point until a picture is visible.
- In the reporting period October 2014 to September 2015, there were 10 unplanned transfers of care from this hospital to a nearby NHS trust. This was better than expected when compared with other independent hospitals and consistently a low rate per 100 inpatient discharges in this reporting period. We reviewed the reasons for the unplanned transfers and found no specific trends.
- For the reporting period October 2014 to September 2015, there were low numbers (five) emergency readmissions within 29 days of discharge.
- There were two cases of unplanned returns to the operating theatre in the reporting period October 2014 to September 2015.
- Patient reported outcome measures (PROMS) for hip and knee replacements (NHS patients only) for the period April 2014 to March 2015 were within the expected range and the England average.
- Patient reported outcome measures (PROMS) for Groin hernia repair (NHS patients only) for the period April 2014 to March 2015 were within the expected range and the England average.
- The hospital took part in national audits focussing on patient outcomes; these included the national joint registry, surgical site infection rates and when appropriate the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- The hospital was undertaking one locally developed commissioning for quality and innovation (CQUIN) in 2015/16. This involved improving patient experience in endoscopy through recording all patients' experience of their endoscopy using the Gloucester comfort score. The results of the score have enabled the hospital to identify areas of the endoscopy pathway needing improvement. The CQUIN had been successfully achieved in all three quarters and the hospital were currently in quarter four and expected to be successful in this quarter. A CQUIN is a payments framework and encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For the patient this means better experience, involvement and outcomes.
- The hospital carried out 70 local audits for example, consent, environment, blood transfusion and nutrition and hydration. We saw where results fell below 90% in an audit actions were in place to improve this, for example a nutrition and hydration audit showed a lack of compliance in fluid balance monitoring. The hospital

had taken action to address this by introducing a new fluid balance and (EWS) chart in addition to providing extra training for all staff. Re-audit results showed improved documentation of fluid balance records and a notable improvement in the theatre documentation of all peri-operative fluids and the pre- ward transfer calculations of all fluids. All fluid balance charts we looked at were fully completed and appeared accurately calculated.

Competent staff

- New staff including bank staff had an induction relevant to their role. One new nurse said their induction was informative. Staff told us there was a flexible approach to the induction period and the length of induction was negotiated with each staff member individually.
- Agency and bank nurses told us they had received an orientation and induction to the ward area. This included use of resuscitation equipment and medicines management records supported this.
- The Resident Medical Officer (RMO) underwent a recruitment process before they commenced employment. This involved checking their suitability to work at the hospital and checks on their qualification. They were mentored by the chair of the Medical Advisory Committee (MAC).
- Consultants carried out the same types of surgical procedures at the hospital as in their substantive role in neighbouring NHS trusts.
- The department leader for the Post Anaesthetic Extended Care Unit (PAECU) had forged links with the local critical care network which had allowed all of the nursing staff on the ward to be trained for critical care transfers from the hospital should they be required.
- Competency assessment programmes were available for theatre staff, for example, one extra competency was scrubbing for orthopaedic procedures in theatres. Staff were not permitted to undertake tasks until they had been deemed competent.
- Staff told us they had access to a set amount of funding for training each year and that this was sufficient for them to access effective training.
- The appraisal rate was greater than 75% for ward care assistants and between 50% and 74% for ward nursing staff and hospital allied health professionals in the reporting period Oct 2014 to September 2015 this was lower than the hospital target of 100%. In the same reporting period there were low levels of staff appraisal (less than 49%) for nurses, care assistants and operating department practitioners (ODPs) working in theatre departments. Theatre department appraisal rates were low due to there being no theatre manager in post for a proportion of the year. A new manager had been appointed and so the hospital were expecting this figure to increase. Additional data provided to us following our inspection showed that the theatre appraisal rate as of March 2016 was 75%.
- There was a system to ensure qualified doctors and nurses' and allied health professionals (AHPs registration status had been renewed on an annual basis. Data provided to us by the hospital showed on the 1 October 2015 there was 100% completion rate of verification of registration for AHPs, 88% for nurses and 92% for doctors. We checked six nurses' registration and found them to be in date.
- There was a robust process in place for granting practicing privileges. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there. For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's (RO) name.
- We reviewed the personal files of 10 consultants working at the hospital under a practicing privileges arrangement. All 10 files demonstrated arrangements for granting and reviewing practising privileges were appropriate and staff were competent and skilled to carry out the care and treatment they provided. We saw where staff had undergone a whole practice appraisal in the last year and had a revalidation date set by the General Medical Council (GMC).
- There was a process in place to ensure appropriate communication was received and passed on to the NHS trust if a consultant's clinical practice raised concerns. Minutes from the clinical governance meeting confirmed this.
- Any clinical practice concerns arising in relation to a consultant would be discussed at the Medical Advisory Committee meetings (MAC). Actions were created and completed before the consultant could practice at the hospital again. MAC minutes confirmed this.

Multidisciplinary working

Good

Surgery

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited and was notably inclusive of managers and team leaders. Staff told us that regular MDT meetings were held in the hospital, minutes we reviewed confirmed this.
- Team briefings were held each morning for theatre staff to review the operating lists and day ahead.
- In theatres, we observed excellent communication and teamwork between staff members.
- There was an MDT approach to pre-operative assessment; this involved nursing and physiotherapy staff. Physiotherapists could identify any equipment patients may need after discharge for example raised toilet seat, and they would issue this at the pre-operative assessment or provide patients with sufficient advice on how to obtain the required equipment.
- There were dedicated endoscopy staff with good team working this was also highlighted in the recent JAG accreditation report.
- A physiotherapist provided input to patients post-surgery and for those patients in the community nursing beds. Physiotherapy was tailored to the individual patient's needs.
- An occupational therapist working on ward two had dedicated links to community services.
- When patients were discharged, the hospital worked well with external services. A letter was sent to the patient's GP to inform them of the treatment and care provided.
- There was good working relationship with the local commissioning group and neighbouring trust in relation to the community nursing beds.
- There were a number of service level agreements in place for services to be supported or provided to the hospital for example the Mid Trent critical care network.

Seven-day services

- The hospital had three operating theatres open seven days per week. Operating times were from 8am until 8pm Monday to Friday and 8am to 6pm Saturday and Sunday. Endoscopy lists ran seven days per week dependent upon activity.
- Consultants practising within the hospital were responsible under practising privileges for care of their patients 24/7.
- There was a Resident Medical Officer (RMO) in the hospital 24 hours a day with immediate telephone access to on call consultants.
- There was an on-call rota for key staff groups, including theatre staff, senior managers, and imaging staff.
- Diagnostic imaging such as x-ray was available Monday to Friday8am to 8pm, with an on call system at weekends. Staff said they did not have any problems accessing this.
- A pharmacy service was provided six days a week, Monday to Saturday.
- Physiotherapy services were available seven days per week

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were paper-based records for each patient; one for medical notes and one for nursing notes; nursing records including observation charts were accessible in the patient's room. This enabled consistency and continuity of record keeping whilst the patient was on the ward, supporting staff to deliver effective care.
- There were computers available on the wards, which gave staff access to patient and hospital information for example policies and procedures.
- Images for example x-rays were available for use by theatres during operations.
- We saw a process in place for obtaining or transferring electronic images from other trusts for use as part of the patients care and treatment in the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for surgical procedures was obtained mostly on the day of surgery by the consultant. Patients confirmed they discussed the procedures with their consultant during outpatients appointments and with a nurse during pre-operative assessment, this allowed time to consider the procedure planned before consenting to treatment on the day of surgery.
- Staff knew the hospital policy on consent. Consent was sought from patients prior to the delivery of treatment. We looked at 10 consent forms during our inspection; consent was fully obtained and recorded in all of the forms we reviewed.

Good

Surgery

- In theatres, we observed staff checking consent forms were signed before proceeding with surgery.
- Staff told us patients who may lack capacity to make an informed decision about surgery were extremely rare. This would be identified at the pre-admission assessment and if any consideration was needed this would be undertaken at this stage. We saw a specific consent form was available for adults who were unable to consent to investigation or treatment. In these cases, a decision was made in the patient best interests, in line with the Mental Capacity Act 2005.
- We saw a policy for Deprivation of Liberty Safeguards and staff were aware how to access this.
- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were clear. Unless otherwise stated, all patients who had a cardiac arrest were to be resuscitated.
- During our inspection, we reviewed two DNACPR forms. Mental capacity decision were recorded on the forms and included patient and family involvement.
- One patient in the community nursing beds had a DNACPR order in place at a neighbouring trust and their DNACPR status had not been reviewed on admission to Woodthorpe hospital. Failure to make timely and appropriate decisions about CPR may leave patients at risk of receiving inappropriate or unwanted attempts at CPR.
- We discussed this with nursing and management staff and they were awaiting a GP visit to assess the patient. We reviewed the Ramsay Health Care UK policy Adult Do Not Attempt CPR and it stated "If an agreement can be reached locally involving those Consultants who this decision (DNACPR) effects and the MAC a standard cross organisation DNACPR order will be accepted". This meant the form from the neighbouring trust would be sufficient for a set amount of time until a doctor in line with the hospital policy had reviewed the patient. Senior managers and staff were not aware of this and no arrangement had been agreed locally. We spoke to the registered manager about this; they said they would work immediately to reach an agreement so this would not happen again.
- On our unannounced visit, we found the same patient had still not had their DNACPR status reviewed by their GP. We escalated this to the hospital manager who said they would contact the GP immediately and request an urgent review.

Are surgery services caring?

Good

The care provided to patients using this service was good. Patients were supported, treated with dignity and respect, and were involved as partners in their care. We found;

- Feedback from patients who used the hospital and those close to them was positive about the way staff treated them.
- Patients were treated with dignity, respect and kindness during all interactions including when they were unconscious.
- Staff spent time talking to patient and those close to them and responded compassionately when patients needed support to meet their basic and personal needs.
- Staff helped patients and those close to them cope emotionally with their care and treatment.

Compassionate care

- The NHS 'Friends and Family Test' is a survey measuring patients' satisfaction with the care they have received and asks if they would recommend the service to their friends and family. For the period April 2015 to September 2015 between 97% and 100% of NHS patients who completed this test would recommend this hospital to family and friends. The response rate was between 45% and 97% for the same reporting period.
- Patients attending the hospital who were not NHS funded were asked to complete an online survey to capture their feedback on the care they received. In the quality account for 2014/2015 91% of patients would recommend care at this hospital.
- We spoke with 10 patients and four relatives / friends during our inspection and received 15 completed comment cards from patients. Without exception, patients reported staff were polite, friendly and approachable, always caring and respectful. Some patients welcomed the relaxed atmosphere, others praised the way staff treated them with dignity, and how nothing was too much trouble.
- Patients were cared for in individual rooms we observed all staff knocking on doors and waiting for a response from staff, patients and or relative before entering and referring to patients by their name of choice.

Good

Surgery

- Staff used the do not enter sign on the patients door when providing care to a patient. This was a further measure used to maintain patient's privacy and dignity and to inform other staff care was being carried out and they should not be disturbed.
- We observed patients remaining covered in the anaesthetic room, operating theatre, recovery areas and during transfers between the ward and theatre areas for their dignity. We observed unconscious patients being communicated with by nursing and medical staff in a compassionate manner.
- Patients told us staff introduced themselves at the beginning of each shift and we observed staff doing so.
- Patients told us staff would always "pop in to check everything was ok".
- Staff assessed patients comfort during endoscopy procedures using the Gloucester Comfort Scale, this takes into account the frequency and duration of discomfort and any distress it might cause the patient, staff responded to the score in a number of ways, for example providing more pain relief or verbal reassurance if required.
- We were told a member of staff had delivered some pre-operative medication directly to a patient's home who was having difficulty getting into the hospital.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were involved and kept up to date with care and treatment plans. They said the staff took time to make sure the patients and relatives understood the care and treatment and the options available.
- We heard doctors discussing treatment options with patient and relatives. Doctors answered any questions raised.
- Patient records we looked at included pre-admission and pre-operative assessments; these took into account individual patient preferences.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.
- We observed patients going into the anaesthetic room were introduced to the surgical team. A handover of the patient from the ward nurse to the theatre staff took place and included the patient. The patient was involved in the whole process and put at ease.

Emotional support

- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.
- Patients told us the staff were understanding, calm, reassuring and supportive and this helped them to relax.
- Patients in the community nursing beds were supported to manage their own health, care and wellbeing to maximise their independence when they left the hospital.

Are surgery services responsive?

Good

We rated the responsiveness of the service as good. Patients' needs were met through the way services were organised and delivered. We found;

- Services were planned and delivered in a way, which met the needs of the local population and individuals. The importance of flexibility, choice and continuity of care was reflected in the services.
- Access to care was managed to take account of people's needs, including those with urgent needs.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- It was easy for people to raise a concern. Complaints and concerns were always listened to taken seriously and responded to in a timely way. Process and systems were in place to agree lessons learned and for sharing of these to ensure improvements were made to care.

However we found:

- The service specification for the community nursing beds and the patients in those beds did not always match; therefore, there was a risk the hospital and the associated environment may not be able to meet the needs of patients outside of the specification.
- The environment on ward two, a ward caring for patients living with dementia was not dementia friendly this meant the full needs of patients living with dementia might not be met.

Good

Surgery

Service planning and delivery to meet the needs of local people

- The hospital had a policy, which outlined the inclusion and exclusion criteria for patients. Patients with an American Society of Anaesthesiologists (ASA) physical status score of four or greater were not treated. The patients admitted to the hospital had an ASA score of one to three. These patients were generally healthy or suffered from mild systemic disease.
- Ward two provided a flexible number of community nursing beds to a neighbouring trust for patients awaiting transfer to alternative care facilities such as care homes. The department leader would assess the suitability of patients to be cared for at the hospital using criteria the hospital had created and by speaking with a central hub. We also reviewed the service specification for this service. During our inspection, we were told by senior managers two patients admitted to the hospital did not meet the service specification. The patients were being cared for appropriately and additional resources were in place to support them during this admission. The registered manager told us they would be speaking with the local commissioner to ensure the specification was adhered to.
- The admission process and care provided was the same for self-funded patients and NHS patients.
- Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff could plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- There was the use of a fourth theatre in the event of an increase in service demand and there were plans in place to extend the ambulatory care model to facilitate more theatre capacity. The hospital had considered plans to increase the number of patient rooms if required. Endoscopy could flex the workforce and number of sessions provided if the demand arose.
- There was access to a patient room with two beds, this facilitated patients who may need to be nursed together whilst an inpatient, for example we heard how an elderly couple who had not been apart since they were married spent their hospital stay together in this room.
- At the time of our inspection ward two, were caring for three patients living with dementia. Ward two was not dementia friendly, for example, there were patterned carpets in the corridors and there were no coloured toilet seats or clear signage and the area was not secure, for example patients who may become disorientated had access to stairs and a lift.
- Unsuitable care environments can have a significant and detrimental effect on patients living with a disability, sight impairment, cognitive problems or living with dementia, leading to additional distress and confusion. This may place them at risk.

Access and flow

- The national standard for referral to treatment (RTT) time states 90% of patients should start consultant led treatment within 18 weeks of referral. Data provided to us showed the RTT was consistently above the 90% target and varied between 93% to 100% for the reporting period October 2014 to September 2015.
- There were staggered admission times for surgery. This meant there was a reduction in patients waiting times for surgery.
- The hospital operated a 24 hour on call service with a 30-minute response time if a patient required a return to theatre.
- The physiotherapy department had introduced a physiotherapy joint school. The joint school was a three-day care pathway for patients who had undergone joint surgeries for example knee replacement. As a result of the joint school there had been a reduction in readmission of joint patients.
- Admission, transfer and discharge of patients from the ward and theatres were managed appropriately. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Theatre staff told us patients identified as high risk, such as diabetic patients, were usually scheduled for surgery at the beginning of the theatre lists in case they developed complications during their procedure.
- Following a referral from a consultant, bookings for surgery were made through the central bookings team this ensured a smooth patient pathway.
- In the reporting period October 2014 to September 2015 the average length of stay for community nursing patients was 22 days and for surgical patients three days.
- In the reporting period April 2015 to January 2016, 28 patients who underwent surgery had an extended

length of stay. We reviewed the data for the patients with extended lengths of stay and saw most reasons related to poor mobility post joint surgery and not meeting physiotherapy milestones prior to discharge.

- Hospital data showed between April 2015 and January 2016 there were 95 cancelled operations. Twenty-four operations were cancelled on the day of surgery for non-clinical reasons such as lack of availability of staff and unavailability of specialist equipment. All patients were readmitted for their operation within one to two weeks following their cancellation date. Fifty-one cancellations were for clinical reasons such patients being unfit for surgery or requiring additional tests prior to surgery.
- The hospital had an occupational therapist (OT) working on ward two. The OT supported patients to facilitate a timely discharge.

Meeting people's individual needs

- Patients admitted to the community nursing beds and for elective surgery over the age of 75 or experiencing memory difficulties were screened for dementia. Records we reviewed and the monthly quality report confirmed all eligible patients had been screened for dementia.
- Patients whose first language was not English could access an interpreter. This was booked before admission if needed. Staff had access to an interpretation phone line for immediate support if required.
- In pre-operative assessment, staff told us they could access sign language services for patients who were hard of hearing or deaf.
- The hospital had a chaperone policy in place. A chaperone is a person who accompanies a patient during an examination for example a female would be accompanied by a female member of staff when being examined by a male member of staff. Staff we spoke with told us every time a chaperone was required they were asked to assist.
- There was a rolling programme in the hospital for staff to attend a "Mental First Aid" course. Mental health first aid is an educational course, which teaches people how to identify, understand and help a person who may be developing a mental health issue. Mental health first aid teachesstaff how to recognise warning signs of mental ill health. At the time of our inspection, 10 members of staff had attended this course and others were scheduled to attend.
- Ward one did not manage a significant number of patients living with severe dementia or learning disabilities but the nurses described how they would care for and manage such patients, they told us it was important to involve family members and / carers in providing aspects of the care and support required.
- Ward two often cared for patients living with dementia and the number were increasing and therefore staff were being encouraged to complete a local e-learning package on dementia so they had a greater understanding of care needs. The hospital was accessing a specialist dementia-training course and had plans in place to ensure all staff attended this. One member of staff working on ward two had previously received dementia training at another trust and the hospital utilised the member of staff's skills for troubleshooting should this be required.
- During our inspection we saw staff delivering care to three patients who were living with dementia, the care we observed showed staff had an understanding of the patients' needs for example one patient who was becoming agitated and requesting to go outside was escorted and supervised outside by staff. This is considered distraction therapy. When the patient returned to the ward, they appeared much more settled.
- At the time of our inspection ward two had three patients living with dementia; however we did not see those patients had any form of communication passport in place. A communication passport is a simple and practical tool. Patients living with dementia can use the documentation to tell staff about their needs, preferences, likes, dislikes and interests. It enables health and social care professionals to see the patient as an individual and deliver person-centred care tailored specifically to their needs. It can therefore help to reduce distress for the patient living with dementia. It can alsohelp to prevent issues with communication.
- The endoscopy lead told us how they had facilitated the admission of a patient with a learning disability for their procedure in conjunction with their carers and GP. They said patients who had a learning disability could have their carer or advocate present in the procedure room if this helped.

- Staff told us relatives could stay overnight in the patient's rooms if required.
- The pre-operative assessment identified patients living with dementia or a learning disability and this allowed the staff to decide whether they could accommodate these patients or refer them to another healthcare provider who could meet their needs. Staff told us a carer would normally accompany patients living with dementia or a learning disability.
- Patients received sufficient information prior to their planned surgery. They were provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. Risks were explained to them.
- Information leaflets given to patients were available in English only. A member of staff told us they could obtain leaflets in other languages if required, however these were not readily available nor was this made known to patients who may be using the hospital.
- All patients with the exception of those in the Post Anaesthetic Extended Care Unit (PAECU) were cared for in individual rooms with private ensuite facilities, which helped maintain their privacy and dignity.
- There was an equipped multi-faith room available in the hospital so patients, staff and relatives of differing religious beliefs, or none at all, could spend time in contemplation or prayer.
- Most of the patients we spoke with commented positively on the choice of food available. The hospital provided three meals a day for in-patients. Choices could be seen on the menus and included choices for those on special diets.
- The ward kitchens had sufficient food stocks to enable staff to supply sandwiches, soup, toast and cereals if patients were hungry at any time.
- The hospital's PLACE scores for February 2015 to June 2015 were lower than England average when compared to other independent sector acute hospital for organisational food 86% compared to England average of 92% and ward food 91% against an England average of 94%. The hospital had plans in place for catering services improvements in nutrition and hydration one improvement was an introduction of a new small portion traditional menu for elderly patients.
- The hospital had introduced a red tray system for vulnerable patients. We saw the red tray system was used effectively by the ward team and catering staff during our inspection. Catering staff were informed of the patient's nutritional needs at the start of their shift. The red tray system is an initiative whereby all meals are served by the catering department on red trays allowing for the easy identification of patients who required assistance to maintain their nutritional and hydration requirements.
- We saw a whiteboard in the ward kitchen had any special dietary requirements highlighted on it, for example a patient with an allergy to a specific food and a patient requiring a liquefied diet due to swallowing difficulties.
- We saw and patients told us water in their water jugs was changed regularly and topped up when required. This meant patients had access to fluids.
- Equipment such as plate guards and adapted cutlery for patients who might be having difficulties with eating were not available in the hospital. Beakers were available for those who required these to drink. We saw staff supporting patients to eat where this was required.

Learning from complaints and concerns

- The hospital had received 48 complaints from patients or relatives between October 2014 and September 2015. They had policies and procedures in place relating to complaint handling. This included ensuring all complaints were logged and reported. A letter was sent to the complainant acknowledging the complaint. The contact details for the general manager, matron and quality improvement manager were included in the letter. Patients were encouraged to contact the provider if they were not satisfied with the response. An open invite was included so patients could meet with the general manager in person to discuss their concerns.
- We reviewed three complaints files, relating to surgery, from the last year preceding our inspection. We saw where all three complaints were handled effectively and confidentially. The complainant had been regularly updated and, files demonstrated where changes to practice had occurred as a result of the complaint.
- The hospital had 'Hot Alert'; this gave patients opportunity to comment on their visit. Senior management team and heads of departments could complete a verbal complaint report form with additional notes of conversation made if required, this encouraged immediate resolution of complaints at local level and reduced the need to raise a formal complaint.

Good

Surgery

- Complaints, outcomes and lessons learned were shared at heads of department meetings and relevant complaints were cascaded down to the department teams through monthly team meetings. Teams were encouraged to share their ideas to improve processes and reduce the likelihood of a complaint occurring again. Nursing staff told us, and staff meeting minutes confirmed complaints were shared with the team. The hospital had introduced a complaints lessons learned forum. The forum involved all members of staff associated with a complaint, sharing the lessons learned and any common themes or trends.
- We were given examples of learning from complaints such as a change to the bookings process. Admission times were now staggered during longer surgical lists to avoid long waiting times for patients. Another example was the introduction of intentional rounding on the wards following complaints whilst waiting for surgery patients did not have enough contact with nursing staff.
- Complaints involving consultants were raised with the chair of the Medical Advisory Committee (MAC) to take forward. In the complaints files we reviewed we saw an example of where a complaint involving a consultant was to be discussed with the MAC.
- An information booklet included information on how to make a complaint was available in each patient room. Patients told us they were encouraged to read this.
- The hospital actively participated in a peer review using the Patients Association Good Practice Standards on complaints handling. This showed the hospital was committed to continually improving its handling of complaints and ensuring lessons were learned across the hospital in response to patient feedback.

Are surgery services well-led?

Good

The leadership of the service was good. The leadership, governance and culture promoted the delivery of high quality person-centred care. We found;

- There was a clear statement of vision and values, driven by quality and safety.
- Strategic objectives were supported by quantifiable and measurable outcomes.
- Structures, processes and systems of accountability including governance were clearly set out, understood and effective.
- Departmental leaders had the experience to lead the services and prioritised safe, high quality compassionate care.
- Candour, openness and honesty were evident.

However;

- Service developments were not always developed or assessed with input from appropriate members of the clinical team and as such, there may not always be an understanding of the impact on the quality of care as a result of the developments.
- There was mixed staff feedback in relation to new sickness reporting process.

Vision and strategy for this this core service

- The hospital had adopted the corporate Ramsay mission known as the “Ramsay Way” this was a culture which recognised people, substantively employed staff and doctors with practicing privileges were the company’s most important asset and this was said to be key to the organisation’s ongoing success.
- The hospital staff had developed the ‘Woodthorpe’ acronym to underpin the hospital strategy. The values were based on what staff aspired to and included ‘W’ Welcoming, ‘D’ Dedicated to providing an excellent quality service and, ‘R’ responsive to the needs of the patient. The care we observed being delivered by staff and behaviours we observed during our inspection demonstrated staff were working in line with hospital values.
- We saw the hospital strategy, which was based around striving for excellence in all that is done. Continually improving the quality of the care and services. Offering a range of current technologies proven to improve clinical outcomes, which support patient returning back to their normal activities sooner, and investing in the hospital estate, facilities, equipment, services and staff to ensure the hospital remained at the forefront of delivering modern health care**.**
- We saw each ward had individual objectives with a mission statement for the ward and what the ward aimed to do.

Governance, risk management and quality measurement for this core service

Good

Surgery

- There was a clear governance structure in place with committees such as clinical governance, senior management and heads of department feeding into the medical advisory committee (MAC) and hospital management team.
- A number of different staff groups met to discuss issues related to incidents, risk, complaints management and clinical audits. These groups included the hospital's medical advisory committee, learning review group and the integrated clinical governance committee. All staff groups were represented at these meetings.
- A clinical governance report was compiled each quarter. This was presented and discussed at the medical advisory committee (MAC) meetings.
- Consultant surgeons were represented on the MAC.
- Incidents, complaints and reviews of surgical procedures were presented and discussed at the MAC. Evidence from the meeting minutes showed actions were made and reviewed.
- The hospital had appointed a local quality manager to work alongside the matron and general manager. The quality improvement manager reported and managed the elements of clinical risk in order to improve outcomes. This demonstrated the hospitals commitment to quality and patient experience.
- Risk registers were in place for all areas and were held at both department and hospital level. Department leaders we spoke with knew and were seen to be managing risk pertinent to their clinical areas.
- Department leaders carried out risk assessments where risks to the service were identified, for example, the breakdown of an endoscope washer and staffing levels on the wards.
- An '11.15am stand-up huddle' was held daily with senior managers and matrons of the service. Staff told us they were encouraged to take issues to this meeting. We attended one of these meetings and saw a joint approach to addressing issues and concerns within the departments. During the meeting, levels of accountability were clearly defined with individuals taking responsibility for issues within their own clinical areas.
- The hospital created a quality newsletter to keep staff updated on any developments within the service or any areas of concerns; this was available electronically and in paper form.

Leadership / culture of service related to this core service

- Senior managers had the capacity, capability, and experience to lead effectively. Managers were of good character, physically and mentally fit, had the necessary qualifications, skills and experience for the role, and had supplied certain information, this included a disclosure and barring service (DBS) check and a full employment history.
- Departmental leaders had the experience to lead the services and prioritised safe, high quality compassionate care.
- Departmental leaders were available in all areas of the hospital and were visible to staff. Staff told us who they would approach if they had any concerns and would not hesitate to do so.
- The department lead in endoscopy had shown a dedicated, enthusiastic and cohesive approach in delivering high quality patient care by achieving Joint Advisory Group on Gastro-intestinal Endoscopy (JAG) accredited status for the hospital. This was reflected in the JAG report.
- The hospital matron provided professional leadership for all clinical staff.
- Staff said the matron and hospital director were visible and they could approach them without question for guidance and support when necessary. For example, during our inspection, a department leader contacted the matron about an issue they wished to discuss and the matron attended the ward shortly after and offered support.
- All of the department leaders we spoke with said they were proud of their team.
- Staff we spoke with told us they felt there was a culture of openness within the hospital.
- Staff we spoke with described immediate managers and members of the senior team as having adopted an 'open door' policy.
- We observed staff were mostly positive about working for the hospital. Staff were committed to providing good quality care and understood the contribution they made personally to the care and treatment of patients, however six out of nine nursing staff we spoke to were worried about the level of nursing staff and issues with recruitment, but were aware senior leaders were working to address this issue.

- Staff told us service developments were not always developed or assessed with input from appropriate members of the clinical team and as such, there may not always be an understanding of the impact on the quality of care as a result of the developments for example an increase in the community nursing bed provision from five to 14.
- There had been a recent change to the sickness reporting procedure at the hospital in response to high sickness levels. Staff were asked to report sickness directly to the hospital manager who could be contacted 24/7. Some staff told us this made them feel like previous sickness episodes were not genuine and felt it was an attempt to get staff to come into work despite being unwell. We discussed this with the hospital manager who told us, by staff reporting to an identified individual, this avoided messages involving sickness reporting not being passed on to the relevant departments in a timely manner. The manager also felt this demonstrated their commitment to the welfare of their staff.
- Staff told us they received good support and regular communication from their managers. For example, one staff member who worked in endoscopy said they were satisfied with their work life balance. Another member of staff said it was like a "breath of fresh air" working at this hospital.
- Most staff told us the hospital had a positive regard for their welfare and could accommodate their additional needs however a small number of staff told us they considered that the provider did not have a positive regard for their welfare. We were given examples where members of staff had required support and assistance in their personal lives and the hospital had not provided them with support.
- Staff said they were encouraged and supported to develop. One member of staff told us they had a number of roles in the hospital and had been encouraged to progress in their career.

Equality and Diversity

- This inspection was part of a pilot programme testing how we assess the Workforce Race Equality Standard (February 2016). The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers and independent acute providers that deliver £200k or more of NHS-funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.
- On day one of our inspection a 'Workforce Race Equality Standard' report dated February 2016 was made available. This report indicated the hospital had 128 members of staff of which nine were from a visible black and minority ethnic community (BME) background.
- We discussed WRES with the hospital manager and, the corporate human resources (HR) director. We were told there was no local strategy in place to address the WRES requirements. The HR director acknowledged that the organisation as a provider of NHS health care had a duty to be compliant in line with its standard contract obligations, but that this had not been addressed and currently there was no provision for delivering on its duty. The HR director told us they would be responsible for the delivery of equality and diversity.
- During our inspection we spoke with five BME staff. They all reported no concerns and felt they were supported by the managers and generally were happy working at this hospital. Staff reported adequate support for continuous professional development in their roles.

Public and staff engagement

- Staff routinely participated in team meetings across the wards and theatres we inspected, they were also able to attend other meetings within the hospital if they chose, for example governance meetings.
- The hospital manager held regular 'Diary room' sessions where staff could go and speak to the manager about any concerns, ideas or suggestions they may have.
- The staff satisfaction score for the year 2014/15 was in line with the Ramsay average.
- The hospital had a monthly VIP recognition awards system. Staff nominated each other in recognition of going above and beyond in their day to day work. Winners were selected by the hospital management team and received a prize. We were told about a member of staff who had worked tirelessly in a specific period had been selected to receive a VIP award.
- The hospital had a proactive employee engagement action group.
- Regular open events took place where prospective patients could come to the hospital and receive a

presentation from a specialist consultant surgeon on the types of treatments available. Patients then had the opportunity to have a mini one-to-one advice session with one of the consultant surgeons.
- GPs were sent regular newsletters and updates, and information packs containing details about the hospital and how to refer patients to the hospital.
- A patient engagement group had recently been developed to ensure inclusion and involvement of patients and to facilitate feedback from patients about the service they had experienced.
- The hospital had forged links with the local university and had facilitated student nurse placements at the hospital; these were due to start following our inspection.

Innovation, improvement and sustainability

- The department lead for endoscopy was in discussions with the local commissioning group to further develop the endoscopy service for example to offer bowel screening.
- The hospital provided some facilities for a clinical research company i.e. ultrasound.
- There were plans in place to create an ambulatory care area and third theatre within the existing theatre area within the hospital. There were also plans to upgrade the fourth theatre on the top floor to accommodate a wider variety of procedures.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient and diagnostic imaging department at Woodthorpe Hospital provide outpatient clinics and diagnostic imaging services to both self-funding and NHS patients. These are provided for adult patients only.

The outpatient department consists of 10 consulting rooms, split over two areas, the East Wing and the West Wing. Clinics are held for 27 different specialities including general surgery, dermatology, gynaecology, spinal and orthopaedics. In addition, there is a treatment room and a dedicated ophthalmology and ear nose and throat (ENT) room.

The diagnostic and imaging services offers plain film radiography, fluoroscopy and ultrasound scans.

Physiotherapy is also contained in the outpatients department and provides a range of treatments including rehabilitation following orthopaedic surgery, acupuncture, shockwave therapy and hand therapy. There is also an integrated gymnasium.

The outpatients had 25,153 attendances between October 2014 and September 2015, 67% of these were attendances by NHS patients.

As part of this inspection, we visited all outpatient locations and diagnostic imaging areas. We spoke with seven patients and two relatives, 27 staff including managers, doctors, registered nurses, physiotherapists, radiographers, health care assistants and administration and reception staff. We observed care and treatment and looked at four patient records. Information provided by the hospital before the inspection was also reviewed.

Summary of findings

Outpatient and diagnostic imaging services were good in the four domains we rated; safe, caring, responsive and well-led.

Patients were protected from abuse and avoidable harm. Staff we spoke with understood their responsibilities to raise concerns and report incidents. They understood their safeguarding responsibilities and demonstrated an understanding around consent and the Mental Capacity Act (MCA) 2005. Patient risks were assessed and steps taken to minimise these risks. Medicines and records were stored securely.

Care reflected national guidance, and staff received training to be competent in their role. The diagnostic and imaging department participated in the hospital audit schedule. There was good multi-disciplinary working and effective working relationships throughout the department and the rest of the hospital.

Staff treated patients in a respectful, kind and professional manner, maintaining their privacy and dignity at all times. Patients and their relatives were pleased with the standard of care they received. The friends and family test (FFT) results for January 2016 reported that 99% of the NHS patients would recommend the outpatients and diagnostic and imaging department to their family and friends. However, response rates to the friend and family test (FFT) were low (7%).

Services were designed to meet the needs of the population and all patients were seen within 18 weeks of referral to the hospital.

Good

Outpatients and diagnostic imaging

There was a clear vision and strategy for the service. There were clear lines of accountability in the outpatients and diagnostic imaging department. Staff spoke positively about their line managers.

Effective governance systems were in place and lessons were learnt and changes in practices resulted in response to complaints.

There was however, nursing vacancies within the outpatients department, although active recruitment was ongoing. In addition, not all staff within the outpatients department had completed their mandatory training.

The environment within the department was not compliant with HBN 00-09. There were hand operated taps and carpeted floor in the consulting rooms. However, the hospital had plans to address this. A small number of staff were not seen to adhere to the bare below the elbow policy.

There was no monitoring of waiting times for patients once they have arrived in the department or cancellation rates of clinics.

Staff were concerned that the service was growing too quickly and they worried that the rate of growth was unsustainable.

Are outpatients and diagnostic imaging services safe?

Good

The safety of this service was good. Patients were protected from avoidable harm and abuse. We found;

- Staff were aware of their responsibilities to report incidents. Learning from incidents had taken place, and changes to practice made as a result.
- Equipment was readily available, maintained and serviced.
- Medicines and records were stored securely.
- All staff within diagnostic imaging were up to date with mandatory training.
- Staff assessed and responded appropriately to potential risks to patients.
- Staff we spoke with understood their safeguarding responsibilities.

However we found;

- There was nursing vacancies within the outpatients department, although active recruitment was ongoing and bank staff were employed to ensure a safe service was maintained.
- Not all staff within the outpatients department had completed their mandatory training.
- The environment within the department was not compliant with HBN 00-09. There were hand operated taps and carpeted floor in the consulting rooms. However, the hospital had plans to address this.
- Not all staff were compliant with the bare below the elbow policy.

Incidents

- Staff reported incidents through the trust's electronic reporting system. Staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses. Staff said they were encouraged to report incidents.
- All incidents were investigated by the head of department and discussed at the monthly clinical governance meetings; department heads would discuss

findings from relevant incidents with their staff. Staff confirmed that they received feedback and we saw evidence that feedback was shared at meetings within diagnostic imaging.

- For 2015, outpatient and diagnostic imaging reported 38 incidents through the trusts electronic reporting system. Fourteen of these related to suspected wound infections for patients who were seen in follow up clinics, so may not have been attributed directly to the care in the outpatient department.
- The service had reported one Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) related event during 2015, which related an x-ray being taken on the wrong part of the body.
- We saw evidence of learning and changes to practice as a result of incidents. For example, there had been a change in the start-up procedure for the fluoroscopy room, following an incident where the radiographer had been exposed to radiation. This meant the hospital had taken steps to improve safety for both patients and staff in the diagnostic and imaging department.
- Staff were aware of the duty of candour, although had not had cause to apply it. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents', offer an apology and provide reasonable support to that person.'

Cleanliness, infection control and hygiene

- The outpatient and diagnostic imaging department were visibly clean and tidy.
- All of the consultation rooms had sinks and taps that were non-compliant with HBN 00-09 infection control in the built environment. The taps were hand operated and had separate hot and cold water taps which is not advised in HBN 00-09. Taps should be elbow operated or sensor operated to avoid re-contaminating hands, and should run via mixer taps to allow staff to wash their hands safely to avoid any potential for scolding.
- The sinks were housed within cabinets and had recesses available for plugs to be fitted on to them, although no sinks were found to have plugs fitted. Clinical sinks should be wall mounted, allowing effective cleaning.
- All consultation rooms apart from one were fitted with carpet flooring which was non-compliant with HBN 00-09. We confirmed with staff in the department that minor clinical procedures had occurred in the consultation rooms. Flooring should be of a material that is compliant with HBN 00-09, which allows for appropriate decontamination. Staff informed us there were plans to refurbish the outpatients department, which included the flooring. All carpets were visibly clean.
- We discussed the use of carpets with the hospital manager who told us there was a rolling programme in place to replace the carpets in the clinical areas with vinyl flooring complying with HBN 00-09. Plans we viewed confirmed this and we saw where the rolling programme had commenced with the flooring in one clinic room now compliant with HBN 00-09. Whilst waiting for the refurbishment to be completed, staff told us that if carpets became contaminated, they would remove the carpet and have it replaced. They also told us about a time when this had taken place within the outpatient department.
- There were disposable curtains in all consultation rooms and treatment rooms. These had been dated to indicate when they needed to be replaced, however not all staff were aware how regularly these should be changed.
- A member of staff had recently been identified as the infection prevention and control (IPC) link for the department. We were told that this was a new development and that the staff member was working closely with the hospital IPC lead to raise the IPC profile in the department.
- Staff told us that hand hygiene audits and environmental audits had just started to be conducted for the department. No results were available at the time of our inspection. An environmental IPC audit had been carried out in the diagnostic imaging department in January 2016. Results demonstrated 100% compliance.
- Handwashing facilities, including hand gel, were available in all clinical and communal areas for staff and patients. We saw staff regularly utilise the alcohol hand rubs in accordance with the World Health Organisation's (WHO) '5 Moments for Hand Hygiene'. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.

Good

Outpatients and diagnostic imaging

- Equipment that was not in use in the department had been cleaned after previous use and green 'I am clean' stickers attached to signify that they were ready for use. All items we checked had been appropriately labelled, no items were found to be visibly dirty.
- We observed a member of staff thoroughly decontaminate an item of patient-care equipment after use.
- We saw appropriate facilities for disposal of clinical waste and sharps bins located in the outpatient and diagnostic imaging department. All sharps bins observed were assembled correctly signed on assembly and had their temporary closure mechanism in place.
- Cleaning schedules were displayed in the diagnostic imaging department; these had been signed to indicate cleaning had taken place.
- Personal protective equipment for staff was available throughout the department.
- We observed that not all staff were compliant with the bare below elbow (BBE) policy. We observed two members of staff were wearing additional rings and stoned rings. This did not comply with the BBE policy.
- We observed staff practicing good aseptic non-touch techniques (ANTT) when performing venepuncture.

Environment and equipment

- Resuscitation equipment was available in both the East and West Wings. Single-use items were sealed and in date. In the West Wing, the resuscitation equipment had been checked on a daily basis. In the East Wing, we saw there were two occasions from the 1 February to the 22 February 2016, where the equipment had not been checked.
- Radiographers had been consistently performing quality assurance checks on imaging equipment since October 2015. These were either monthly or every other month, depending on the equipment. We saw evidence of any faults with equipment being logged, reported and repaired appropriately.
- All equipment had been appropriately maintained and serviced. We checked 13 pieces of equipment including for example, laser equipment, electronic blood pressure machines and weighing scales. All had been serviced within the past year and where necessary had received portable appliance testing (PAT).
- We checked consumables in consulting rooms and all were stored appropriately and were in date.
- The phlebotomy lead was responsible for performing daily checks on the portable blood analyser machine; we saw evidence that this had been completed.

Medicines

- Medicines in outpatients were stored in locked cupboards or fridges. The keys to the medicine cupboards were held by a registered nurse. Expiry dates for the medicines we checked were within date. Staff told us pharmacy provided a 'top-up' service for medicines, and could not recall any occasion when there had been a shortfall of medicines. We saw evidence that daily temperature checks of the medicine fridge temperatures had been recorded, and were in acceptable ranges.
- Medicine prescription pads were stored in a locked room that was only accessible by clinical staff. However, NHS guidance (2013) suggests prescription forms should be kept in a locked cabinet within a lockable room or area. The use of prescription pads were monitored with each prescription sheet logged in a book, which identified the serial number of the prescription sheet and the name of the prescriber using it.

Records

- Patient records were stored securely throughout the outpatient and diagnostic imaging department.
- Records for self-funding (non NHS) patients were kept at the hospital at all times. This meant staff had access to patient information including treatment plans at the patients follow-up appointment or, should they require an unexpected return to the hospital.
- For NHS patients, the hospital used a seven page document called the NHS outpatient care pathway. This document was located in the patients' records. However, we reviewed four records of patients who had been seen in the past 24 hours and saw that these were not consistently completed. Staff we spoke with told us that consultants would often dictate notes after the consultation, which would be typed up by the medical secretaries, rather than complete hand written notes at the time. Outcome forms, however, were completed at the time of the consultation for each patient. These forms were attached to the front of the notes and ensured the patient received the correct follow up treatment in a timely manner.
- Physiotherapy records for those patients who had not had surgery were not integrated into the full patient

records. This meant that physiotherapists did not have access to all information regarding the patient. We saw evidence that this had escalated to the senior team and was documented on the physiotherapy risk register.
- The hospital participated in a review by the British Standard Institute (BSI) in September 2016, which looked at the security of patient's records. The review found that a clinic list detailing patient identifiable information had been left in clear view of the public and called for the clear desk policy to be introduced. Staff we spoke with were familiar with the clear desk policy.

Safeguarding

- Within outpatients, 81% of staff had completed their mandatory training, which included safeguarding training. Within diagnostic imaging, all staff had completed this. We spoke to four members of staff, three of which demonstrated understanding of safeguarding issues. However, all four staff knew how to access further advice from the hospital's safeguarding lead.
- Staff had little understanding of female genital mutilation (FGM). Since October 2015, it is mandatory for regulated health and social care professionals to report 'known' cases of FGM, in persons under the age of 18, to the police. Whilst the service did not provide care to those patients under the age of 18, healthcare staff had a professional duty to report any concerns where a parent has had FGM and may have female children.

Mandatory training

- Mandatory training included sessions on fire, manual handling, basic life support, infection prevention and control and safeguarding.
- Within outpatients, 81% of staff had completed their mandatory training; this was below the hospital target of 100%.
- All diagnostic imaging staff had completed their mandatory training.

Assessing and responding to patient risk

- Notices were displayed on the reception desk and in changing rooms of diagnostic imaging, asking female patients of childbearing age to speak with the radiographer if there was any chance of being pregnant.
- Diagnostic reference levels (DRL) were displayed in imaging rooms and local rules guidelines were available in the department in line with the Ionising Radiation Regulations 1999. These were regularly reviewed and cascaded to all staff working with ionising radiation. We saw evidence that staff had signed these, indicating that they had read the guidelines.
- The radiographer manager was the radiation protection supervisor (RPS) as required under Ionising Radiation Regulations 1999 and was responsible for supervising work within the imaging department.
- Staff used the World Health Organisation (WHO) surgical checklist for patients undergoing arthrograms and ultrasound guided injections. The WHO surgical checklist is a core set of safety checks, identified for improving safety at critical time points within a procedure. We reviewed two records of patients who had recently had these procedures and found that WHO surgical checklists had not been completed for either of them. We escalated this to the radiographer manager at the time. The following day, we saw that notices had been placed in the imaging rooms reminding staff to use the WHO surgical checklist and two radiographers confirmed that manager had reminded them verbally of the importance of using the WHO surgical checklist.
- We saw posters displayed in the imaging rooms reminding staff to 'pause and check' to ensure the correct identification of patients prior to imaging.
- We observed patients being asked to confirm their personal details prior to having their bloods taken.
- Processes and agreements were in place to transfer patients to an alternative acute hospital if their condition deteriorated.

Nursing staffing

- Staffing within the outpatients department was planned based on local knowledge of the types of clinics taking place. The use of a staffing tool could help hospital staff measure patient acuity and / or dependency to inform evidence-based decision making on staffing.
- The outpatient department was staffed with 1.6 whole time equivalent (WTE) registered nurses, 4.6 WTE care assistants and 1 WTE nurse manager.
- There was no reported use of agency staff in the outpatients department for the reporting period of October 2014 to September 2015, although the outpatient manager confirmed that regular bank staff were used.
- As of October 2015, there was a vacancy rate of 33% (less than one WTE) reported for registered nurses in the

Good

Outpatients and diagnostic imaging

outpatient department. However, there were no vacancies for care assistants. The outpatient manager confirmed there was active ongoing recruitment in the department.

- There were generally low levels of sickness reported for registered nurses working in the outpatient department during the reporting period of October 2014 to September 2015. There was mixed levels of sickness for care assistants working in the outpatient department. Sickness for care assistants reported in December 2014, April-July 2015 and September 2015, was greater than 20%, however this equated to less than 1WTE.

Radiography Staffing

- There were at 5.7 WTE radiographers in the diagnostic and imaging department, this was slightly over the planned establishment of 5.4 WTE.

Medical staffing

- There were 136 consultants granted practicing privileges at the hospital. The majority of these worked at local NHS trusts. They included consultants with specialties such as ophthalmology and orthopaedics. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there.
- Staff told us that consultants were generally on time for their clinics. However, some consultants were late, usually if they came from local NHS hospitals where they may be delayed by unexpected complications with patients for example. The frequency of delays was not collated or monitored and therefore we were unable to see how often this occurred or the impact it had.

Major incident awareness and training

- The manager for outpatients confirmed they had been involved in developing the hospitals business continuity plan and kept a copy of the policy readily available in the outpatient department's office.
- Routine fire drills took place, this allowed staff to rehearse their response in the event of a fire.
- Generator testing took place each month and was carried out by the onsite maintenance engineer.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We found:

- Care reflected national guidance, and staff received training to be competent in their role.
- There was a hospital audit schedule, which the diagnostic and imaging participated in.
- There was good multi-disciplinary working and relationships were good throughout the department and with the rest of the hospital.
- Staff had an understanding around consent and the Mental Capacity Act (MCA) 2005

However

- There was no process to monitor the unavailability of records for outpatients appointments.

Evidence-based care and treatment

- Staff worked to local policies and care reflected national guidance. For example, physiotherapy treatments were based on NICE guidelines. Treatment of patients with lower back pain was in line with NICE clinical guideline 88, and the use of shockwave therapy was in line with NICE interventional procedure guidance IPG311.
- The hospital promoted a 'policy of the week'; to encourage staff to familiarise themselves with a different policy each week. We saw evidence within diagnostic imaging that staff had signed to say they had reviewed an individual week's policy.
- The imaging department used diagnostic reference levels (DRLs), which act as an aid to ensure patients received the optimal exposure to radiation. We saw these displayed in the imaging rooms.

Pain relief

- Physiotherapists provided various treatments for pain management. These included for example shockwave therapy and acupuncture.
- Patients had access to a consultant led pain clinic via the 'choose and book' system,
- Pain management leaflets were available and posters visible in waiting areas.

Good

Outpatients and diagnostic imaging

- A member of staff was able to give us an example where a patient awaiting surgery attended clinic for a steroid injection, to manage their pain, whilst awaiting an operation date.
- All of the patients we spoke with were not experiencing pain at the time of their attendance in the outpatient department.

Patient outcomes

- The hospital's clinical audit schedule outlined when, how often and who would conduct audits in the various areas. We reviewed the audit information within diagnostic imaging and saw that audits had been consistently completed since October 2015. We saw evidence of action being taken as a result of audits in this area. For example, an audit was carried out to ensure that clinical evaluation had been carried out for all ionising radiation examinations as per the Ionising Radiation (Medical Exposure) Regulations 2000. When compliance fell below 100%, we saw evidence of action plans and conversations with clinicians to remind them of their responsibilities.
- The hospital had undertaken significant work in relation to improving access for patients to NHS prescriptions on site and also auditing and evaluation of medical staff prescribing.
- The outpatient manager was unaware of audits relating to patient outcomes being conducted in the outpatient department, but we saw participation in local audits for example medicine management and patients records. Local audit activity included the physiotherapy department.

Competent staff

- All staff across outpatients and diagnostic imaging services felt that there were good opportunities to develop professionally. They told us they were offered training to update their skills and knowledge relevant to their post.
- Staff we spoke with could all give examples of training course they had completed. These were relevant to their role and included for example, venepuncture or customer service. One member of staff who was new to the department, told us they had been provided with a mentor and felt very supported in their new role.
- All staff within the outpatients and physiotherapy department had had an appraisal in 2015. None of the four staff within diagnostic imaging radiotherapy department had an appraisal in 2015. However, the manager for this area had only been in post since January 2016, and since then had completed initial one-to-one review meetings with all staff and had set dates from appraisals. We saw documented evidence of this during the inspection.
- All staff within diagnostic imaging completed a competence checklist for the use of each piece of imaging equipment. We saw locally held records of these.
- From April 2016, all registered nurses are required to revalidate with the Nursing and Midwifery Council (NMC) in order to continuing practising. We saw posters displayed providing information to support registered nurses to do this. We spoke with one registered nurse who told us that she had been provided with information about revalidation from a senior nursing colleague.
- There was a system to ensure qualified doctors and nurses' and allied health professionals (AHPS) registration status had been renewed on an annual basis. We checked six nurses' registration and found them to be in date.
- There was a robust process in place for granting practicing privileges. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there. For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's (RO) name.
- We reviewed the personal files of 10 consultants working at the hospital under a practicing privileges arrangement. All 10 files demonstrated arrangements for granting and reviewing practising privileges were appropriate and staff were competent and skilled to carry out the care and treatment they provided. We saw where staff had undergone a whole practice appraisal in the last year and had a revalidation date set by the General Medical Council (GMC).

Multidisciplinary working

- Staff told us that communication and working relationships were good throughout the department and with the rest of the hospital. We observed staff worked together as a team.

Good

Outpatients and diagnostic imaging

- The diagnostic imaging manager confirmed there was good support and advice available from their Radiation Protection Advisor and Medical Physics Expert, which was provided externally by an NHS trust.

Seven-day services

- Outpatient services were offered up to six days a week. Monday to Friday clinics ran from 8am to 8pm, and on Saturdays, clinics ran from 8am to 4pm.
- Physiotherapy was available Monday to Friday from 730am to 6pm.
- Diagnostic imaging was available Monday to Friday 8am to 8pm, with an on call system at weekends.

Access to information

- The hospital had a process to ensure that all records were available at the time of consultation, and told us that no patients were seen in clinics without a full medical record being available. However, during our inspection records for two patients were unavailable, this had been escalated to the operations manager and information regarding the patients had been obtained from the medical secretaries, to allow both patients consultations to go ahead. Staff told us that there was no process to monitor the unavailability of records for appointments, so we were unable to assess the impact of this.
- Staff had access to the secure image exchange portal. This meant that staff could access images, such as MRI scans for example that had been taken at other hospitals. This prevented the unnecessary reimaging of patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated an understanding around consent and we saw consent been obtained prior to procedures.
- Senior staff in the department demonstrated some understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. They told us it was rare to have patients who lacked the mental capacity to make decisions, so experience of using the MCA was limited.

Are outpatients and diagnostic imaging services caring?

Good

The care provided to patients using this service was good. Patients were supported, treated with dignity and respect, and were involved as partners in their care. We found;

- Staff treated patients in a respectful, kind and professional manner, maintaining their privacy and dignity at all times.
- Patients and their relatives that we spoke with were pleased with the standard of care they received. The friends and family test (FFT) results reported that between November 2015 and January 2016, 98-100% of the NHS patients would recommend the outpatient and diagnostic imaging to their family and friends.
- Patients and their relatives were provided with relevant information and support whilst attending the outpatients and diagnostic imaging department.

Compassionate care

- The hospital supported the 6Cs initiative. The 6Cs is a national initiative to promote care, compassion, competence, communication, courage and commitment. We saw posters displayed promoting the 6Cs, we spoke to one member of staff about the 6 Cs who demonstrated a good understanding of the initiative.
- We observed the reception staff being very respectful and polite to patients reporting to the department. We also observed them trying to maintain confidentiality when discussing any private details by lowering their voices.
- We spoke with seven patients who told us they were happy with the care that they received at the hospital. One patient who had previously been a patient at the hospital told us “I wouldn’t have come back if the care wasn’t good”.
- The hospital participated in the friend and family test (FFT), in order to seek feedback from NHS patients; however, response rates for these were low, varying between 6-8% between November 2015 and January 2016. Although there was a low response, between 98-100% of NHS patients would recommend the outpatient and diagnostic imaging to their friends and family. FFT cards were visible throughout the

Good

Outpatients and diagnostic imaging

department. Radiographers had recently started to keep a supply of cards in the imaging room to hand directly to patients following their procedure, in order to increase the response rate.

- Patients attending the hospital who were not NHS funded were asked to complete an online survey to capture their feedback on the care they received. In the quality account for 2014/2015 91.6% of patients would recommend care at this hospital.
- We saw positive feedback given to the physiotherapy department by patients including a 'thank you' gift, which had been given to the department for acknowledgement of their kind, compassionate and respectful care.
- We observed staff actively approach patients in a respectful and caring manner when arriving in the department, offering their assistance and helping them to the waiting areas when they had booked in at the reception.
- All the patients we spoke with commented on how nice and friendly the staff were in the outpatients department with one patient describing them as "lovely". One relative however did comment on not seeing a member of staff after being shown into the waiting area and no one had checked to make sure that they were okay whilst waiting for the consultation.
- We observed doctors coming out to meet their next patient due into their clinics and introducing themselves to them before helping them to the consultation room.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us that they fully understood the information given to them about their care, treatments and condition. One patient told us that their consultant had used "simple terms and language that I understand." Patients we spoke with said if they did not understand anything they had been told, they would feel happy about asking the staff to explain things further for them. One patient that we spoke with was happy with the information that they had been provided in their consultation, and had been given a patient information leaflet to support this.
- Patient's relatives and/or carers were encouraged to attend their consultations with them. We saw evidence where relatives were welcomed during a patient consultation with a physiotherapist, and saw active involvement of the relative by the staff member. We also observed relatives, as well as patients, being greeted by the staff when being collected for their consultations.
- Patients were given information who to contact if they had any concerns about their care, treatments and condition. One of the patients that we spoke to had previously had treatment and was told to contact the outpatients department with any concerns if he had them. He did this following a concern and was given an appointment in the outpatient department the next day as well as having information provided for him over the phone.

Emotional support

- We observed staff actively approaching patients after their appointments to make sure that they had no concerns following their consultations and offering support if required.
- We observed a member of staff providing reassurance to a patient whilst undergoing a clinical procedure and making sure that they were comfortable throughout.
- During our visit to the physiotherapy department, we observed a member of staff giving encouragement and reassurance to a patient who was undergoing mobilisation assessment following surgery.

Are outpatients and diagnostic imaging services responsive?

Good

We rated the responsiveness of the service as good. Patients' needs were met through the way services were organised and delivered. We found;

- Services were designed to meet the needs of the population and all patients were seen within 18 weeks of referral to the department.
- Facilities were available within outpatients & diagnostic imaging services to meet patient's individual needs.
- Lessons were learnt and changes in practices occurred as a result of complaints.

However we found;

Good

Outpatients and diagnostic imaging

- Waiting times for patients once they had arrived in the department and cancellation rates of clinics were not monitored.

Service planning and delivery to meet the needs of local people

- The outpatient and diagnostic imaging departments were clearly signposted from the main entrance of the hospital.
- Water dispensers in waiting areas were freely available for patient use and a vending machine was available for hot drinks. Television, magazines, newspapers and children's books were also available.
- All patients who we spoke with told us that there was always adequate amounts of parking available at the hospital.
- A joint working partnership had been established with a local optician to enable a more streamline and effective service for ophthalmology patients.
- The outpatients department had recently introduced a 'one stop' appointment process for patients who were coming to the department from Lincolnshire. This ensured that patients were seen in other departments such as diagnostics and imaging and pre-operative assessment as required, all on one day, to prevent travelling back and forth to the hospital.

Access and flow

- The referral to treat time (RTT) for outpatients was 100%, during October 2014 to September 2015. This meant that all patients were seen within 18 week of referral.
- Patients we spoke with told us they had waited between one and four weeks for their appointment; all were happy with this.
- Between April 2015 and January 2016, the 'did not attend' (DNA) rate was between 0.5 and 1.7%. This was below the hospital target of 5%.
- The hospital did not monitor waiting times for patients once they have arrived in the department, or cancellation rates of clinics. We discussed this with the hospital manager who told us the number of occasions clinics were cancelled were very small and were not considered an issue. A policy was in place whereby consultants gave six-weeks' notice if a clinic needed to be cancelled. Where clinics were to be cancelled the consultant would clinically review all of their follow up patients in that clinic to ensure the delay in their appointment would not compromise their care and pathway.
- Posters were displayed throughout the department, encouraging patients to speak to receptionist if they had been waiting more than 20 minutes. Waiting times for appointments were displayed in both the East and West Wing waiting areas. We saw that on 23 February 2016, one consultant clinic was running 15 minutes late. Staff told us they would speak with patients and explain whenever possible why clinics were running late and provide refreshments to the patient.
- During our visit, two patients attended the outpatient department to see two different consultants. The consultants had not been able to attend their clinic for unavoidable reasons; however both patients had turned up to the outpatients department because this information had not been communicated with them. Both patients were given the opportunity to wait to see their consultant when they arrived later that day or re-book their appointments for another day.
- One of the patients that we spoke with told us that the diagnostic imaging department had informed them that there would be a small delay with their appointment. The patient was happy about this as the department had involved them with the planning of their appointment and given them the chance to change their appointment if they were not happy with the delay.
- One patient that we spoke with told us that they had felt involved with the planning of their appointment when arranging it. They had been told that they expected a small delay with the day that they had selected, therefore giving them the opportunity to change their appointment if they were unhappy with the potential delay
- The physiotherapists told us that if they had a patient who did not attend (DNA) an appointment, they would call to check the patient was safe and to rebook the appointment.

Meeting people's individual needs

- The outpatient department was located on the ground floor and had accessible toilet facilities for disabled patients.

Good

Outpatients and diagnostic imaging

- The hospital had access to an interpretation service. Posters were clearly displayed at the East and West reception areas, providing staff with information on how to obtain interpreting services.
- Patient education posters were displayed throughout the department, for example providing health education about the risk of sun damage to skin. Patient information leaflets were available for common surgical procedures. These were comprehensive and provided clear information and diagrams; however they were only available in English. Information in braille, large print and other languages could be made avilable upon request within 24 hours through the hospitals printing supplier. One patient that we spoke to was given a leaflet to support the information which he had been given during the consultation.
- Posters were displayed throughout the department, encouraging patients to ask if they would like a chaperone.
- Equipment such as couches, chairs and weighing scales where available for bariatric patients.
- The imaging department had four changing rooms for patients to use, which contained a lockable wardrobe so patients could store their belongings safely.
- Staff gave an example of the reasonable adjustments that had been made for a patient living with dementia who recently had attended the department.
- There was a multi-faith room available in the hospital so patients, staff and relatives of differing religious beliefs, or none at all, could spend time in contemplation or prayer.

Learning from complaints and concerns

- We reviewed two complaints files, relating to outpatients, from the last year preceding our inspection. We saw where both complaints were handled effectively and confidentially. The complainant had been regularly updated and, files demonstrated where changes to practice had occurred as a result of the complaint.
- Lessons were learnt and changes in practices occurred as a result of complaints. As a result of a complaint where an image was not available via the image exchange portal (IEP) radiographers amended the process for obtaining these. Similarly, staff within outpatients told us they now displayed waiting times for clinics in response to a complaint made by a patient.
- Physiotherapists told us that complaints were discussed at the lessons learnt forum.
- Leaflets were available for patients in the waiting area, which provided details of how to complain.

Are outpatients and diagnostic imaging services well-led?

Good

The leadership of the service was good. The leadership, governance and culture promoted the delivery of high quality person-centred care. We found;

- There was clear vison and strategy for the service.
- Effective governance systems were in place.
- There were clear lines of accountability and responsibility in the outpatients and diagnostic imaging department. Staff spoke positively about their line managers.
- Staff were passionate about patient care and enjoyed working at the hospital. They felt there was an open and transparent culture where patients were put first.

However we found;

- There was mixed staff feedback in relation to new sickness reporting process.

Vision and strategy for this this core service

- The 'Ramsay Way' vision was displayed in the outpatient area as well as objectives for the outpatient department. The objectives for the department were aligned to hospitals values, including for example aiming to provide compassionate care to patients.
- Ramsay's values were reflected in the conversations we had with staff and we observed the values being displayed in the interactions staff had with patients, relatives and each other.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework to support the delivery of good quality care.
- The hospital had appointed a local quality manager to work alongside the matron and general manager. The quality improvement manager reported and managed the elements of clinical risk in order to improve outcomes. This demonstrated the hospitals commitment to quality and patient experience.

Good

Outpatients and diagnostic imaging

- Clinical governance meetings were held monthly and were attended by the heads of department. These meetings fed into the medical advisory committee (MAC) and hospital management team. We saw evidence of incidents, complaints and patient feedback, for example, being discussed at these meetings. One doctor we spoke with told us that governance arrangements had improved recently and they now felt there was a robust system in place.
- An '11.15 stand-up huddle' was held daily with senior managers and matrons of the service. Staff told us they were encouraged to take issues to this meeting. We attended one of these meetings and saw a joint approach to addressing issues and concerns within the departments. During the meeting, levels of accountability were clearly defined with individuals taking responsibility for issues within their own clinical areas.
- Risk registers were in place for all areas. Department leaders we spoke with knew and were managing their identified risks. For example the outpatient manager was able to discuss actions taken to reduce the risk of reduced nursing staff numbers. Physiotherapy staff were able to discuss the risks in their own area with us, and we saw these reflected in the risk register. We saw evidence that these risks and been escalated to the senior management team.
- We saw evidence that risk assessments for the use of specific equipment had been completed appropriately within both physiotherapy and diagnostic imaging.
- The diagnostic imaging manager attended Ramsay wide meetings, where governance issues were discussed. We saw agendas and presentations from these meetings and saw that incidents were discussed and lessons leant across the organisation.
- There was awareness that a 'rolling programme' was in place to upgrade the environment within the outpatients department.

Leadership / culture of service

- Senior managers had the capacity, capability, and experience to lead effectively. The hospital manager was of good character, physically and mentally fit, had the necessary qualifications, skills and experience for the role, and had supplied certain information, this included a disclosure and barring service (DBS) check and a full employment history.
- There were clear lines of accountability and responsibility in the outpatients and diagnostic imaging department.
- Managers within outpatients and diagnostic imaging department spoke positively about the senior management team and were confident that the senior management team would continue to raise the profile of the hospital and put patients first. They felt comfortable escalating concerns and felt able to influence decisions.
- We spoke to three members of staff about reporting sickness to the hospital manager. Two staff said they felt uncomfortable doing this as they would rather prefer to talk to someone they knew. We discussed this with the hospital manager who told us, by staff reporting to an identified individual, this avoided messages involving sickness reporting not being passed on to the relevant departments in a timely manner. The manager also felt this demonstrated their commitment to the welfare of their staff.
- Radiographers we spoke with were positive about their line manager. They felt supported, engaged and able to influence the service. Nurses and healthcare assistants within the outpatients department told us that their line manager provided supportive leadership; one commented, "she's always got time for you" another said "she listens to you."
- All staff we spoke with were clearly passionate about patient care. Staff said they enjoyed working at the hospital, thought it was a happy environment and found their work rewarding. Staff told us there was an open and transparent culture in the hospital and patients were put first.

Equality and Diversity

- This inspection was part of a pilot programme testing how we assess the Workforce Race Equality Standard (February 2016). The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers and independent acute providers that deliver £200k or more of NHS-funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.

Good

Outpatients and diagnostic imaging

- On day one of our inspection a 'Workforce Race Equality Standard' report dated February 2016 was made available. This report indicated the hospital had 128 members of staff of which nine were from a visible black and minority ethnic community (BME) background.
- We discussed WRES with the hospital manager and, the corporate human resources (HR) director. We were told there was no local strategy in place to address the WRES requirements. The HR director acknowledged that the organisation as a provider of NHS health care had a duty to be compliant in line with its standard contract obligations, but that this had not been addressed and currently there was no provision for delivering on its duty. The HR director told us they would be responsible for the delivery of equality and diversity.
- During our inspection we spoke with five BME staff. They all reported no concerns and felt they were supported by the managers and generally were happy working at this hospital.

Public and staff engagement

- Radiographers told us they felt the communication between other departments had improved. One consultant said that the hospital was small and this aided communication between the departments.
- Staff we spoke with told us they were kept up to date, either by conversation or meetings with their line mangers or by emails from senior team. Staff were aware of vision to expand service to seven days and knew they were hospital were recruiting extra staff.
- The hospital manager held regular 'diary room' sessions where staff could go and speak to the manager about any concerns, ideas or suggestions they may have
- The staff satisfaction score for the year 2014/15 was in line with the Ramsay average of 4.6.
- The hospital had a monthly VIP recognition awards system. Staff nominated each other in recognition of going above and beyond in their day to day work. Winners were selected by the hospital management team and received a prize. We were told about a member of staff who had worked tirelessly in a specific period had been selected to receive a VIP award.
- The hospital had a proactive employee engagement action group.
- Regular open events took place where prospective patients could come to the hospital and receive a presentation from a specialist consultant surgeon on the types of treatments available. Patients then had the opportunity to have a mini one-to-one advice session with one of the consultant surgeons.
- GPs were sent regular newsletters and updates, and information packs containing details about the hospital and how to refer patients to the hospital.
- A patient engagement group had recently been developed to ensure inclusion and involvement of patients and to facilitate feedback from patients about the service they had experienced.
- The hospital had forged links with the local university and had facilitated student nurse placements at the hospital; these were due to start following our inspection.

Innovation, improvement and sustainability

- Staff in the outpatients department informed us about refurbishment plans that were in place to improve the outpatients department.

Outstanding practice and areas for improvement

Outstanding practice

- There was a rolling programme in the hospital for staff to attend a "Mental First Aid" course. Mental health first aid is an educational course, which teaches people how to identify, understand and help a person who may be developing a mental health issue.
- An '11.15 stand-up huddle' was held daily with senior managers and matrons of the service. This allowed for a joint approach to addressing issues and concerns within the departments. During the meeting, levels of accountability were clearly defined with individuals taking responsibility for issues within their own clinical areas.
- The hospital arranged bi-monthly infection control meetings with links to microbiologists at a local NHS trust. This was a proactive group with representation from all departments to ensure each part of the patient's pathway was safeguarded against the risks of infections.
- Patients were asked about smoking and alcohol consumption as part of their pre-operative assessment. All identified smokers and patients who were deemed to be at risk of alcohol related complications were given advice leaflets.
- A target controlled infusion (TCI) system was used in theatres for the administration of anaesthetics. TCI avoids over dosage of a patient with anaesthesia and allows the anaesthetist to adjust the levels of drug administered according to patient need.
- The hospital promoted a 'policy of the week'; to encourage staff to familiarise themselves with a different policy each week.
- The hospital was undertaking a locally developed(CQUIN) in 2015/16. This involved improving patient experience in endoscopy through recording all patients' experience of their endoscopy using the Gloucester comfort score.
- The department leader for the Post Anaesthetic Extended Care Unit (PAECU) had forged links with the local critical care network which had allowed all of the nursing staff on the ward to be trained for critical care transfers from the hospital should they be required.
- The Physiotherapy department had introduced a physiotherapy joint school. The joint school was a three-day care pathway for patients who had undergone joint surgeries for example knee replacement. As a result of the joint school there had been a reduction in readmission of joint patients.

- The physiotherapists told us that if they had a patient who did not attend (DNA) an appointment, they would call to check the patient was safe and to rebook the appointment.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure that they comply with reporting requirements for the Workforce Race Equality Standard.
- The hospital should ensure all medicines on the resuscitation trolleys are in date and ready for use.
- The hospital should ensure medicines trolleys are stored in line with hospital policy, current legislation and best practice guidance.
- The hospital should ensure there are processes in place to assess, monitor and improve the quality of services in the outpatients department including the monitoring of cancellations and delays.
- The hospital should ensure flooring in clinical areas is compliant with HBN 00-09 infection control in the built environment.

Outstanding practice and areas for improvement

- The hospital should ensure medicine prescription pads are stored in a locked cabinet within a lockable room or area locked room in line with NHS guidance (2013).
- The hospital should ensure there is an improvement in mandatory training rates.
- The hospital should consider reviewing the process for admission to the community nursing beds to ensure that the patients admitted to the hospital meet the service specification for the community nursing beds.
- The hospital should consider reviewing the environment on ward two to make it dementia friendly.
- The hospital should consider equipping theatre four with all of the standard equipment associated with a theatre for example piped oxygen and suction units in line with HBN 26 Facilities for surgical procedures.