New Hall Hospital

Quality Report

New Hall Hospital
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Date of inspection visit: 10 & 11 August 2016
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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

We carried out this inspection as part of our programme of independent healthcare inspections under our new methodology. The comprehensive inspection was carried out through announced visits on 9 and 10 August 2016. We did not carry out an unannounced inspection.

We did not inspect the mobile MRI scanner, in the grounds of New Hall Hospital, as this was operated by a third party.

We rated the hospital as good overall with surgery, outpatients and diagnostic imaging services, rated as good in all domains. We did not rate effective for outpatients and diagnostic imaging services due to insufficient evidence being available.

Are services safe at this hospital/service

- The hospital promoted a culture of reporting and learning from incidents. Incidents were fully investigated with actions for improvement identified and put into place. Staff were familiar with the duty of candour regulation. We saw evidence it had been applied when the service investigated incidents/complaints.
- There was a resident medical officer on duty 24 hours a day who was competent to deal with clinical emergencies.
- The management of medicines and infection control was in place with audit tools used to monitor practice.
- Staff were clear about safeguarding practices and knew what actions to take if they had concerns. However the service was not clear how many staff had completed their safeguarding training since the organisation had moved to a new recording system.
- Records were stored securely and audited for compliance with protocols.
- Nursing and medical records had been completed appropriately and in line with each individual patient's needs.
- Surgical safety checklists were completed as required and a modified early warning score system was in place to support staff to recognise a deteriorating patient.
- The provider was not assured that all relevant staff had received their mandatory training since a new system of recording had been introduced within the organisation.
- Infection rates were monitored.
- The radiology department hand a sink with no hot water and soap which did not comply with recommendations for hand hygiene although other sinks were available for staff to use.
- There were service level agreements with the local acute trust if patients needed to be transferred from New hall hospital. However the hospital did not have sufficient assurance about the maintenance and water quality in a hydro pool, which was at the local acute trust, to ensure it was safe for their patients to use.

Are services effective at this hospital/service

- Needs were assessed and treatment was provided in line with legislation and using National Institute for Health and Care Excellence (NICE) guidance. Staff were aware of the guidance relevant to their area of work.
- Policies and procedures incorporating national guidance were in place and available to all staff. Staff knew where to access guidance and policies.
- The service had achieved Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) for its endoscopy service.

Summary of findings

- Staff training and appraisal was ongoing. Although the provider was not assured that all relevant staff had received their mandatory training since a new system of recording had been introduced within the organisation.
- Consent to care and treatment was discussed and obtained in line with legislation and guidance.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Regular audits were carried out to monitor performance against corporate and national patient outcomes and to maintain standards.
- Patients were at the centre of the service and the priority for staff. High quality performance and care were encouraged. All staff were engaged in monitoring and improving outcomes for patients.
- The Medical Advisory Committee (MAC) met regularly and were proactive. Consultants were only granted practising privileges once their information had been scrutinised and agreed by the MAC.

Are services caring at this hospital/service

- Patient feedback about the service was positive. Patients said staff were kind, caring and supportive. We saw staff were kind and caring, their focus being on individualised patient care.
- The FFT response rate for NHS patients, at New Hall Hospital, ranged from 29 % in January 2016 to 34% in October 2015. This was lower than the England average of around 40%, for the same reporting period. However, the satisfaction scores were higher than the England average for the same reporting period ranging from 97% to 100% satisfaction with the service.
- Staff ensured people's privacy and dignity was respected. In the NHS FFT 99% of responders said they were treated with privacy, dignity and respect.
- Staff communicated well with patients to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- There were different visiting hours for NHS and self-pay patients. The service said this had come about as NHS patients usually stayed in shared bays where lengthy visiting hours had been reported, by patients, to be affecting their wellbeing. Self- pay patients always had a single room and therefore visiting was allowed for longer as it did not affect other patients. The service said if patients in shared bays wanted flexible visiting hours this could always be accommodated,
- We observed staff treating patients with kindness and warmth. They were polite, calm and reassuring. The ward and departments were busy and well run, but staff always had time to provide individualised care.

Are services responsive at this hospital/service

- Services were planned to meet patients' needs. The flow of patients through the hospital was well organised.
- There was 24 hour medical cover on site to enable the service to respond to any emergencies
- Patients felt well informed about their procedure and what to expect during their recovery.
- Services were tailored to meet the needs of individual patients and were delivered in a flexible way. In June 2016 the service opened a dementia friendly room. The room had been made to look less like a hospital room and had room for family and friends to stay with the patient as necessary.

Summary of findings

- There was level access into the building and a passenger lift to all floors ensuring patients could move around the building.
- Complaints were responded to in a timely manner and any learning was taken forward to develop future practice.
- Staff actively invited feedback from patients and their relatives and were very open to learning and improvement.

Are services well led at this hospital/service

- The hospital had a vision for developing the service and shared this with their staff.
- There were clear governance processes in place to monitor the service provided.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice would be introduced, shared throughout the hospital and monitored for compliance.
- Leadership at each level was visible. Staff felt listened to and had confidence in their managers.
- The leadership, governance and culture of the service helped to drive and improve the delivery of high-quality care. The heads of departments were committed to the patients in their care, their staff and the ward/unit.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- Staff said they were proud of their ward/departments as a place to work. They showed commitment to the patients, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary
- Audit and governance processes were in place and reported to leadership and governance committees.
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital.

Our key findings were as follows:

We saw several areas of outstanding practice including:

- Staff learning needs were identified and they were encouraged and given opportunities to develop. All staff we spoke with said they were supported and funded to undertake extra training and were given time to complete this. For example, one member of staff said they had requested to attend a training course that would be beneficial to their role. Another member of staff told us they had been approached by their manager and given the opportunity to attend the same course as they were employed in a similar role.
- There was strong evidence of a good culture among staff, and shared vision and objectives to improve patient care.
- There was strong focus on improving quality of care and people's experiences by monitoring feedback, complaints and reported incidents.

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

Importantly, the provider must:

- Ensure all departments have appropriate sinks, hot running water and soap to comply with infection control measures and that when audits suggest non-compliance, that this is actioned promptly.

In addition the provider should:

Summary of findings

- Continue to consider the benefit of an on-call pharmacy service.
- Ensure there is a system in place to check the temperature of the room used to store back up medicines so staff were able to assure themselves these medicines were always kept at a safe temperature.
- Ensure patients medical history and reason for admission, especially when being transferred from another hospital, are clear in the patient care record and the blood test results pages are always completed.
- Ensure the system put in place to improve compliance with safeguarding training, by directly employed consultants, is monitored and improvements are being made and all staff have received the necessary training.
- Continue to review processes for ensuring directly employed consultants are compliant with mandatory training requirements
- Ensure information relating to workforce race equality standards can be produced at a local level as well as at a corporate level.
- Ensure the service reviews their process for monitoring daily cleaning of equipment and surfaces in clinical areas.
- Review processes for ensuring maintenance and water quality meet requirements to ensure its safe use for patients.
- Review their uniform policy to ensure compliance with national recommendations regarding effective washing of all parts of the uniform.
- Monitor and log the use of prescriptions in the outpatient department to ensure there is an audit trail.
- Ensure the use of the World Health Organisation (WHO) checklist for patients having minor surgery is audited for compliance and actions are taken if required.
- Review process and service level agreements to include information about maintenance and water quality, with a local NHS trust for the use of their hydro pool.
- The outpatient department should audit compliance with chaperone attendance in line with their policy.
- Review and agree processes to ensure all patients receive a discharge letter in case of the need to seek assistance in a medical emergency.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	• Staff were encouraged and supported to report incidents. Learning from incidents was evident across the hospital and shared with other Ramsay Healthcare hospitals. • Systems were in place to monitor patient safety, including the World health Organisation (WHO) surgical safety checklist, were in place and well managed. • Treatment was provided in line with national best practice guidance and staff were aware of the National Institute for Health and Care Excellence (NICE) guidance related to their practice. • Policies and procedures were in place to support staff and were available to staff at all times. • Feedback from patients and their relatives about the care and support provided was positive. Staff were seen to be kind, caring and able to provide individualised care. • Services were planned to meet patient's needs. The flow of patients through the hospital was well organised. • Complaints were responded to according to Ramsay Healthcare's policy. Learning was taken from complaints to continue to develop good practice. • There were clear governance processes in place to monitor the services the hospital provided. Mangers were visible at each level. They were approachable and responsive. Staff had confidence in the leadership team.
Outpatients and diagnostic imaging	Good	• Incidents were reported and acted upon and risk was managed. Feedback and learning was shared with staff. • Treatment and care were effective, and delivered in line with best practice and recognised national guidance.

Summary of findings

- Patients were at the centre of the service and the priority for all staff. Feedback from people who had used the service was positive. Patients spoke very highly of the staff and the care and support they were given.
- Patients received care from dedicated, caring staff who were skilled in working with and communicating with patients and their families.
- Services were designed and delivered to meet patient's needs.
- There were clear lines of accountability and lines of management in place. The management team were described as approachable. The culture of the service drove improvement and the delivery of high quality care.
- There were clear systems in place for managing governance and measuring quality.

Summary of findings

Contents

Good

Location name here

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

Summary of this inspection

Background to New Hall Hospital

New Hall Hospital is an independent hospital, which is part of the Ramsay Healthcare corporate group. It has been providing hospital services in Salisbury since 1980. Ramsay Healthcare bought the hospital in 2007 and has been running it since that date. It provides outpatient and surgical services to adults only.

The hospital had one ward, divided into three areas (Tryon, Longford and Upper Creasey) with 32 inpatient beds and five day- case beds provided in single en-suite rooms. There were 11 beds in the surgical admissions unit and eight in the day- case unit (pods). There were four operating theatres within the theatre suite. Endoscopies were carried out in theatre four. There was a six bay recovery (post-anaesthetic) area in the theatre suite.

The outpatient department had nine consulting rooms, a phlebotomy (blood taking) room and two treatment rooms.

The diagnostic imaging service provided a range of specialist imaging services including standard (plain film) X-rays, computerised tomography (CT) scans and magnetic resonance imaging (MRI) scans.

The physiotherapy outpatient services included musculoskeletal disorders (MSK) clinics and post-operative rehabilitation following orthopaedic surgery.

The general manager had been in post for seven and a half years and the matron had been working at the hospital for 13 years and five months, 12 of those as matron.

Our inspection team

Our inspection team was led by: Mandy Norton, Inspector, Care Quality Commission.

The team included two CQC inspectors, a CQC pharmacist and four specialists: a consultant surgeon, a consultant physician, a theatre manager and a radiographer.

Why we carried out this inspection

We carried out this comprehensive inspection as part of our scheduled in depth inspections of independent hospitals.

How we carried out this inspection

We carried out this comprehensive inspection as part of our scheduled in depth inspections of independent hospitals.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider :

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

The inspection team inspected the following two core services at the New Hall Hospital:

- Surgery.
- Outpatient and diagnostic imaging services.

Summary of this inspection

Prior to the announced inspection, we reviewed a range of information we held about the service for example minutes of meetings, audit data and training records.

Our announced visits took place on 9 and 10 August 2016. During our visit, we spent time on the ward and in the outpatient department observing the treatment and care provided. We also spent time in the surgical admissions unit, operating theatres and recovery areas.

We spoke with the management team of the hospital, the deputy chair and the anaesthetic representative of the medical advisory committee, a variety of staff, including nurses, healthcare assistants, doctors, therapists, radiographers, department managers and support staff. We also spoke with patients and relatives.

We reviewed comments made by patients on comment cards available to patients before our inspection visit. We saw care being given to patients. We reviewed 20 sets of patient's records.

Before and after our inspection we reviewed information and data provided about the service. We spoke with local stakeholders for example the local clinical commissioning group, to find out their views of the service provided by the hospital.

Information about New Hall Hospital

New Hall hospital has been operating as a hospital since 1980 and has been managed by Ramsay Health Care since 2007. It provides outpatient, surgical and some medical services to adults from eighteen years upwards to the people of Salisbury and surrounding areas. Spinal services are also provided for patients who live in the wider South West area.

New Hall Hospital was previously inspected by CQC in January 2014 prior to the change to the new fundamental standards. At that inspection all areas inspected were found to be compliant.

The hospital had one ward, divided into three areas (Tryon, Longford and Upper Creasey) with 32 inpatient beds and five day- case beds provided in single en-suite rooms. There were 11 beds in the surgical admissions unit and eight in the day- case unit (pods). There were four operating theatres within the theatre suite. Endoscopies are carried out in theatre four, which is also compliant for Endovenous Laser Therapy (EVLT) used for treatment of varicose veins. There is a six bay recovery (post-anaesthetic) area in the theatre suite, with five being operational at the time of the inspection. The matron was the controlled drugs accountable officer (CDAO).

There were 4,449 inpatient and day case episodes of care between April 2015 and March 2016. Of these 59% were NHS funded the remaining 41% of patients were self-pay or funded by their insurance companies.

The five most common surgical procedures performed between April 2015 and March 2016 were:

- Lumbar epidural (319)
- Knee arthroscopy (290)
- Root block injection (167)
- Total hip replacement (124)
- Arthroscopic sub acromial decompression (124).

Between April 2015 and March 2016 there had been 266 endoscopies carried out:

- Colonoscopy - 95
- Gastroscopy – 92
- Double (gastroscopy & sigmoidoscopy) – 41
- Sigmoidoscopy – 38

Between April 2015 and March 2016, the outpatient department held 29,876 appointments of which 67% were NHS funded appointments and 33% were private appointments. These included 8,949 new referrals and 20,927 follow up appointments.

The hospital also provides outpatient appointments for NHS patients for spinal services in Poole and Dorchester hospitals and at Blandford clinic for general and orthopaedic services. We did not inspect any of these locations during our inspection of New Hall Hospital.

Summary of this inspection

The outpatient department is part of a recent extensive refurbishment, which also included a new spinal theatre complex and a day - case unit. The department has nine consulting rooms, a phlebotomy (blood taking) room and two treatment rooms. The services include a variety specialities, including audiology, cardiology, gastroenterology, orthopaedics, urology and the pre-assessment clinic, The department offer outpatient services six days a week and is open from 8am to 8pm Monday to Friday and on Saturday from 8am to 1pm.

The five most common outpatient consultations between April 2015 and March 2016 were:

- Spinal 35%
- Orthopaedics 23%
- Ear, nose and throat 5%
- Gynaecology 5%
- General surgery 5%

Between August 2015 and end of July 2016 the radiology department facilitated 4992 plain film X-rays, 1766 ultrasound examinations and 773 fluoroscopy procedures (a study using a continuous x-ray beam passing through the body part being examined). In the same period, the hospital facilitated 2387 Magnetic Resonance Imaging (MRI) scans and 407 computerised tomography (CT) scans using the visiting mobile scanner. The department is open five days a week from 8.30am to 6.30pm (8.30pm on some days) and two Saturdays a month. In addition, the department offers a 24 hour on call service for theatre/ward patients.

The physiotherapy outpatient services include musculoskeletal disorders (MSK) and post-operative rehabilitation following orthopaedic surgery. The department treated 959 day patients, 920 inpatients and 4170 outpatients. It is open five days a week from 8.30 am to 8pm.

From October 2015 to March 2016, two patients accessed the medical care services, 115 patients used the endoscopy service and ten patients were cared for in the oncology service (facilitated by the hospital, but not provided by the hospital). Information about these services is incorporated into the surgery report.

What people who use the service say

Patients and their relatives had high praise and positive comments about the hospital, the services offered and the staff who worked there.

Comments like " I have received care of an extremely high level", "friendly and engaged staff" and "cleanliness of the facility was excellent, as was the standard of catering" we made on the comment cards left with the service prior to the inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- The hospital promoted a culture of reporting and learning from incidents. Incidents were fully investigated with actions for improvement identified and put into place. Staff were familiar with the duty of candour regulation. We saw evidence it had been applied when the service investigated incidents/ complaints.
- There was a resident medical officer on duty 24 hours a day who was competent to deal with clinical emergencies.
- The management of medicines and infection control was in place with audit tools used to monitor practice.
- Staff were clear about safeguarding practices and knew what actions to take if they had concerns. However the service was not clear how many staff had completed their safeguarding training since the organisation had moved to a new recording system.
- Records were stored securely and audited for compliance with protocols.
- Nursing and medical records had been completed appropriately and in line with each individual patient's needs.
- Surgical safety checklists were completed as required and a modified early warning score system was in place to support staff to recognise a deteriorating patient.
- The provider was not assured that all relevant staff had received their mandatory training since a new system of recording had been introduced within the organisation.
- Infection rates were monitored.
- The radiology department did not have hot water and soap to comply with recommendations for hand hygiene.
- There were service level agreements with the local acute trust if patients needed to be transferred from New hall hospital. However the hospital did not have sufficient assurance about the maintenance and water quality in a hydro pool, which was at the local acute trust, to ensure it was safe for their patients to use.

Are services effective?

Good

- Needs were assessed and treatment was provided in line with legislation and using National Institute for Health and Care Excellence (NICE) guidance. Staff were aware of the guidance relevant to their area of work.

Summary of this inspection

- Policies and procedures incorporating national guidance were in place and available to all staff. Staff knew where to access guidance and policies.
- The service had achieved Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) for its endoscopy service.
- Staff training and appraisal was ongoing. Although the provider was not assured that all relevant staff had received their mandatory training since a new system of recording had been introduced within the organisation.
- Consent to care and treatment was discussed and obtained in line with legislation and guidance.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Regular audits were carried out to monitor performance against corporate and national patient outcomes and to maintain standards.
- Patients were at the centre of the service and the priority for staff. High quality performance and care were encouraged. All staff were engaged in monitoring and improving outcomes for patients.
- The Medical Advisory Committee (MAC) met regularly and were proactive. Consultants were only granted practising privileges once their information had been scrutinised and agreed by the MAC.

Are services caring?

Good

- Patient feedback about the service was positive. Patients said staff were kind, caring and supportive. We saw staff were kind and caring, their focus being on individualised patient care.
- The FFT response rate for NHS patients, at New Hall Hospital, ranged from 29 % in January 2016 to 34% in October 2015. This was lower than the England average of around 40%, for the same reporting period. However, the satisfaction scores were higher than the England average for the same reporting period ranging from 97% to 100% satisfaction with the service.
- Staff ensured people's privacy and dignity was respected. In the NHS FFT 99% of responders said they were treated with privacy, dignity and respect.
- Staff communicated well with patients to reduce their anxieties and keep them informed of what was happening and involved in their care.

Summary of this inspection

- Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- There were different visiting hours for NHS and self-pay patients. The service said this had come about as NHS patients usually stayed in shared bays where lengthy visiting hours had been reported, by patients, to be affecting their wellbeing. Self-pay patients always had a single room and therefore visiting was allowed for longer as it did not affect other patients. The service said if patients in shared bays wanted flexible visiting hours this could always be accommodated,
- We observed staff treating patients with kindness and warmth. They were polite, calm and reassuring. The ward and departments were busy and well run, but staff always had time to provide individualised care.

Are services responsive?

Good

- Services were planned to meet patients' needs. The flow of patients through the hospital was well organised.
- There was 24 hour medical cover on site to enable the service to respond to any emergencies
- Patients felt well informed about their procedure and what to expect during their recovery.
- Services were tailored to meet the needs of individual patients and were delivered in a flexible way. In June 2016 the service opened a dementia friendly room. The room had been made to look less like a hospital room and had room for family and friends to stay with the patient as necessary.
- There was level access into the building and a passenger lift to all floors ensuring patients could move around the building.
- Complaints were responded to in a timely manner and any learning was taken forward to develop future practice.
- Staff actively invited feedback from patients and their relatives and were very open to learning and improvement.

Are services well-led?

Good

- The hospital had a vision for developing the service and shared this with their staff.
- There were clear governance processes in place to monitor the service provided.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice would be introduced, shared throughout the hospital and monitored for compliance.

Summary of this inspection

- Leadership at each level was visible. Staff felt listened to and had confidence in their managers.
- The leadership, governance and culture of the service helped to drive and improve the delivery of high-quality care. The heads of departments were committed to the patients in their care, their staff and the ward/unit.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- Staff said they were proud of their ward/departments as a place to work. They showed commitment to the patients, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary
- Audit and governance processes were in place and reported to leadership and governance committees.
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital

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	Requires improvement	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Information about the service

New Hall Hospital carried out routine, non-urgent surgery for adults who met strict eligibility criteria. The hospital had one ward, divided into three areas (Tryon, Longford and Upper Creasey) with 32 inpatient beds and five day - case beds provided in single en-suite rooms. There were 11 beds in the surgical admissions unit and eight in the day case unit (pods). There were four operating theatres within the theatre suite. Endoscopies were carried out in theatre four, which was also compliant for Endovenous Laser Therapy (EVLT) used for treatment of varicose veins. There was a six bay recovery (post-anaesthetic) area in the theatre suite, with five being in use at the time of our inspection.

There were 4,449 inpatient and day case episodes of care between April 2015 and March 2016. Of these 59% were NHS funded the remaining 41% of patients were self-pay or funded by their insurance companies.

The five most common surgical procedures performed between April 2015 and March 2016 were:

- Lumbar epidural (319)
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Between April 2015 and March 2016 there had been 266 endoscopies carried out:

- Colonoscopy - 95
- Gastroscopy – 92
- Double (gastroscopy & sigmoidoscopy) – 41
- Sigmoidoscopy – 38

The surgical admissions unit (SAU) and the day- case unit were open Monday to Friday from 8am to 8.30 pm and 8am to 5 pm on Saturdays. Theatres one and two were open Monday to Friday from 8 am to 8 pm 8am to 2pm on Saturdays. Theatres three and four were open Monday to Friday from 8am to 9pm and from 8am until 2pm on Saturdays. There was a 24 hour on call service overnight, Sundays and on bank holidays.

During the inspection we visited the operating theatres, recovery area, surgical admission unit, the inpatient ward and the sterile supplies department. We spoke with 13 patients, two relatives and 32 staff. These staff included consultant surgeons, consultant anaesthetists, the senior management team, matron, nursing staff, operating department practitioners, health care assistants, sterile supplies department staff, administrative staff, catering manager, catering staff, housekeeping staff and student nurses.

Good

Surgery

Summary of findings

Overall we rated the New Hall hospital surgical services as good because:

- Staff were encouraged to report incidents. Learning was taken from incident investigations and shared internally and across the whole organisation.
- Systems were in place to monitor patient safety, including the World Health Organisation (WHO) five steps to safer surgery surgical safety checklist, We found these to be well managed.
- The hospital had Joint Advisory group (JAG) accreditation and Endoscopy Global ratings Scale (GRS) (recognition granted to organisations that meet standards that require continuous improvement in structures, processes and outcomes) for its endoscopy service
- Medicines were well managed and stored securely. They were able to ask for and received pain relief in a timely way if needed.
- Medicines were available within the hospital as needed. The hospital had a pharmacy store that was staffed from 8am until 3pm Monday and Thursday and from 8am until 2:30pm Tuesday, Wednesday and Friday, with arrangements for access outside of these hours. A pharmacist was available in the hospital for four hours Monday to Friday.
- Treatment was provided in line with national guidance and best practice. Staff were aware of the National Institute for Health and Care Excellence (NICE) guidance relating to their practice.
- Policies and procedures were in place to support staff and were available to staff at all times. The policies and procedures were regularly reviewed.
- Staff had mandatory and role specific training to enable them to competently provide care and support needed by patients.
- Feedback from patients and their relatives about the service and the care provided was positive. Staff were caring and sensitive to patient's needs.
- Services were planned to meet patient's needs. The flow of patients through the hospital was well organised.
- Complaints were responded to and managed in a timely way. Learning was taken from complaints to further develop good practice.
- There were clear governance systems in place to monitor the services the hospital provided.
- Staff had confidence in the leadership team. Managers were visible and available to all levels of staff. Consultants were approachable and supportive.

Good

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- There was a positive culture around reporting and learning from incidents. Incidents were investigated with areas for learning identified and shared with staff.
- There were systems in place to manage medicines and infection control practices.
- Nursing and care staff knew what actions they had to take if they had any safeguarding concerns.
- Records were stored securely and audited for compliance with Ramsay health UK policies and procedures.
- Surgical safety checklists were completed as required and a modified early warning score system was in place to support staff to recognise a deteriorating patient.

However:

- There was no on-call pharmacy service out of hours.
- There was no thermometer to check the temperature of the rom used to store back up medicines therefore, staff were not able to assure themselves these medicines were always kept at a safe temperature
- The medical history and reason for admission, especially when being transferred from another hospital, was not always clear in the patient care record and in some records the blood test results pages were not completed.
- Information supplied by the hospital showed the overall compliance for safeguarding training was 69%. Doctors showed the lowest level of compliance at 37%.This figure was low due to the directly employed consultants not being up to date with their safeguarding training. Doctors who were not directly employed by the service and had been granted practising privileges had to attend mandatory safeguarding training in their roles in the NHS and provided New Hall Hospital with evidence that the training had taken place and they were up to date.

Incidents

- Out of the 130 clinical incidents, reported between April 2015 and March 2016, 91% (118) occurred in surgery or surgical inpatients. All incidents were categorised and investigated in accordance with Ramsay Health Care UK 'Incident Reporting' policy and any trends noted were discussed with the relevant department and at Medical Advisory Committee (MAC) meetings and governance meetings. We saw minutes of both meetings from April and May 2016 that confirmed this happened. We reviewed investigation reports and found thorough investigations had taken place and evidence of learning that had been shared with relevant departments.
- There were seven non-clinical incidents reported, at New Hall hospital, between April 2015 and March 2106. This is lower than other independent acute hospitals we hold data for over the same reporting period.
- There were systems in place to record incidents, concerns or near misses using an electronic reporting system. Staff we spoke with were able to describe the reporting procedure for all incidents. They understood their responsibilities to raise concerns and how to report incidents. They said feedback was received from incidents reported at weekly team meetings and through monthly 'bite size' bulletins, which were also displayed in the staff dining room.
- The hospital reported eight serious incidents in the period from April 2015 to March 2016. This was higher than expected when compared to a similar group of independent acute hospitals.
- There were no unexpected deaths between April 2015 and March 2016. All patient complications were reviewed by the MAC.

Duty of Candour

- Staff we spoke with had a good understanding and knowledge of when to apply the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the hospital to be open and transparent when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Staff spoke confidently about the duty of candour. Relevant staff had received training.

- We reviewed three serious incident investigation reports and found they discussed the outcomes with patients/ relatives involved, in an open way and offered appropriate apologies.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The safety thermometer was completed for all NHS patients one day each month. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This covers areas including falls, venous thromboembolism (VTE) and catheter associated urinary tract infections.
- The provider reported VTE screening rates of over 95% between April 2015 and March 2016.
- There were five incidents of hospital acquired VTE or pulmonary embolism (PE) in the same reporting period. The clinical governance meeting minutes from April 2016 stated that the VTE risk assessment document was to be added to the consent form to improve compliance with VTE screening. We saw completed VTE risk assessments in the patient records we reviewed.

Cleanliness, infection control and hygiene

- All areas of the hospital we visited appeared visibly clean. We saw staff followed hospital procedures for infection prevention and control. They were bare below the elbow and used personal protective equipment and hand gel appropriately. All infection control policies were Ramsay Health UK corporate policies and were accessible to all staff via the Ramsay Health Care intranet system.
- Cleanliness in the theatre suite and ward areas was seen to be of a good standard. We saw up to date cleaning rosters, which had been completed and signed by staff.
- The 2015 Patient-led assessment of the care environment (PLACE) for the hospital scored 98% for cleanliness, which equalled the national average.
- The hospital had no incidences of clostridium difficile or methicillin-resistant staphylococcus aureus (MRSA) from April 2015 to March 2016.
- The minutes of the May 2016 Infection Prevention and Control Committee were well attended and detailed. They showed that an annual local infection control plan was in place and reviewed annually. They also detailed training relating to hand washing techniques. This information was available and instructions on correct handwashing techniques were displayed to improve hand hygiene compliance amongst all staff groups.
- A summary of all infections was submitted to, and discussed at the Medical Advisory Committee (MAC) meetings and emailed to all relevant consultants.
- There had been 20 surgical site infections (SSI) between April 2015 and March 2106. Fourteen of those were spinal infections. The rates were similar to NHS hospitals for spinal infections, however, the hospital carried out detailed internal investigations as to the causes. The resultant action plan for 'addressing the rise in spinal infections' had some recommendations around staff movement in and out of theatre and where more information was needed if a patient already had a suspected infection. However there was also building work ongoing during the period of increased spinal infections and it was thought the rise may be due to an excess dust during the building work. There were no significant SSIs before or since the building work had taken place. The SSIs had not been attributed to one consultant or procedure.
- We saw daily cleaning records were completed to identify when and where staff had completed their cleaning. Cleaning staff undertook daily cleaning of the ward and theatre suite.
- Staff in the endoscopy department showed us the procedures they used to clean the scopes. They were knowledgeable about the process and used personal protective equipment when carrying this out.
- The hospital had a 'bare below elbows' policy and we saw staff observing the policy. We saw that clinical staff washed their hands between patients.
- There was a comprehensive audit calendar to monitor compliance with infection control and prevention procedures such as hand hygiene and cleaning. We reviewed some of the audits and generally found that compliance was good. However, we saw a consultant wearing long earrings.

Environment and equipment

- Resuscitation equipment was available and fit for purpose. The resuscitation equipment was tamper evident and checked daily. At the time of our inspection, all checks were up to date. The equipment was stored in a corridor with unobstructed access to it.
- The hospital had a system for reporting damaged or faulty equipment. Staff we spoke with were able to describe the process for reporting damaged or faulty equipment. In the endoscopy department, the hospital had a contract with a third party provider for the repair and maintenance of equipment and they reported this system worked well.
- Equipment safety checks were undertaken daily in the operating theatres. The anaesthetic machines were checked again by the anaesthetist prior to use.
- The on-site sterile services department (SSD) provided the sterile equipment for theatres. There was a dirty utility corridor at the back of theatres 1-3. SSD staff collected the used equipment and transferred it to their department. We saw the department was well laid out and there were systems in place for checking and monitoring the equipment used. Sterile equipment was taken to the clean store behind the theatres as required, segregated appropriately from the dirty utility corridor.
- The lists for surgery were prepared in advance, which enabled staff to plan for and order equipment. The theatre manager said they worked really well with their on-site sterile surgical supplies (SSD) team and had good working relations with the SSD team at the local acute NHS trust when needed.
- Three of the operating theatres had laminar flow; this is a specialised air filtration system which helps to reduce the risk of infections.
- **Medicines**
- Medicines were available within the hospital as needed. The hospital had a pharmacy store that was staffed from 8am until 3pm Monday and Thursday and from 8am until 2:30pm Tuesday, Wednesday and Friday, with arrangements for access outside of these hours. A pharmacist was available in the hospital for four hours Monday to Friday.
- When the pharmacy was closed, nursing staff were able to access emergency packs of take home medicines for patients. Staff told us they were able to access the pharmacy out of hours in an emergency; but rarely needed to do this. Staff told us they could also access medicines from outside the hospital, in an emergency, if needed. This helped to ensure that the medicines patients needed were always accessible. However, there was no on-call pharmacy service out of hours. Staff told us they thought the pharmacy system worked very well.
- The pharmacy provided a regular restocking service to the theatre areas and the ward. Staff were able to make additional orders if needed. Systems were in place to identify any medicines with a short expiry date, so pharmacy staff could replace them at the appropriate time.
- The pharmacist visited the ward every weekday to monitor patients' prescription and administration charts and complete medicines reconciliation. Medicines reconciliation checks patient's medicines to make sure they continue to receive their prescribed medicines correctly whilst in hospital.
- The hospital manager told us they were looking at increasing the number of hours a pharmacist was available in the hospital, following changes in the hospital's workload. The pharmacy staff confirmed that it was difficult for them to carry out checks and audits and make improvements to the service, whilst also completing their routine work in the contracted hours. We saw two audits of the completion of medicines reconciliation. Staff had documented how their ability to complete this was affected by other competing work.
- Doctors prescribed people's medicines on specifically designed prescription and administration charts. We looked at eight of these records. Prescriptions met legal prescribing requirements and staff recorded patient's allergies. Staff recorded the medicines they had given or used a code to record the reason, if they had not given a medicine. Records showed staff gave medicines as prescribed. However, we saw one patient's record with a gap in the record for two medicines; staff had not recorded they had given medicines or a reason if they were not given. So this could be investigated staff recorded this as a medication error.
- We saw nurses give six patients their medicines at lunchtime using a safe and caring method. Staff asked patients if they needed pain relieving medicines and explained which medicines they could give and at what

times. This helped patients understand and have some control of their treatment. Staff told us they had shown two patients how to give their own injection so they would be able to continue do this when they went home.

- Patients were encouraged to bring in their own medicines in the labelled containers so staff could administer these whilst they were in the hospital. The nurses told us they usually gave patients their take home medicines and discussed these with them. We heard one nurse discussing a patients take home medicine with them. The patient was clear about what they should take and why.
- Emergency medicines and equipment were available. Staff checked the sealed emergency trolley daily and the medicines weekly to make sure they were always safe for use. The pharmacy kept information about the expiry date of medicines included, in the trolley, so they could replace them as necessary.
- Medicines were stored securely. Medicines refrigerators were available and staff recorded the temperatures daily. Records showed these were kept at a safe temperature for storing medicines. Staff also recorded the room temperatures where medicines were stored. Records showed that one clinic room on the ward was often above the recommended safe temperature for storing medicines. Staff had taken action to address this by opening the window and using a fan but said that further action might be needed. The issue had been escalated to the senior management team. Staff in theatres had a back-up stock of medicines, which they used to top up the theatre stocks. There was no process in place to check the temperature of this room, so staff were not able to assure themselves these medicines were always kept at a safe temperature.
- Suitable arrangements were in place for storing controlled drugs, which needed additional security. Staff made suitable records of the use of these medicines to demonstrate they were managed safely. Staff made regular checks of the records. The home office had undertaken a recent inspection and renewed the licence held by the hospital for the keeping of controlled drugs.
- The service had an accountable officer responsible for the safe management of controlled drugs. The accountable officer attended the Controlled Drugs Local Intelligence Network meetings; they also provided quarterly information returns to the network. This helped to promote the safe use of these medicines.
- Medicines were managed safely in the oncology service. Medicines arrived at the hospital prior to each clinic and were stored in a drug fridge as per the manufacturers guidelines. The fridge temperature was checked daily and we saw up to date records of this. Prior to administration, the medicine and patient were checked by two members of staff. If a patient was receiving a new drug for the first time, the nurse administering it ensured there was an anaesthetist available in case of an adverse reaction to the drug.
- Systems were in place for staff to report, record and learn from medicines related incidents. The pharmacist was not able to access this system but could give information to nursing staff to put on the system. Staff told us that the provider's group chief pharmacist shared information about medicines errors across all of Ramsay Healthcare's hospitals via a newsletter. This helped to share learning and protect patients from similar incidents recurring.

Records

- Care records were managed in a way that maintained confidentiality. We did not see any unattended records during our inspection in the theatre suite or on the ward and we saw patient notes were securely stored in a locked trolley.
- The six patient care records we read were accurate and legible. They had detailed pre-operative assessments and risk assessments completed. However, the medical history and reason for admission, especially when being transferred from another hospital, was not always clear in the patient care record and in some records the blood test results pages were not completed.
- Records of the patient's time in theatre were fully completed; they included the World Health Organisation (WHO) five steps to safer surgery surgical safety checklists.
- The hospital had introduced the use of an electronic patient portal for patients to complete medical questionnaires and registration forms online. The system was safe as the patients had to create their own

passwords and the data was encrypted. The hospital held an ISO 27001 accreditation for information security, which meant there was a high standard of information security that managers audited regularly.

Safeguarding

- No safeguarding concerns involving patients had been raised from April 2015 to March 2016. Staff we spoke with were aware of their responsibilities around safeguarding.
- The hospital had systems and processes in place to safeguard adults and visiting children. The hospital had a safeguarding adult's policy, safeguarding of children and young people policy, that both incorporated information and a flowchart to follow in relation to female genital mutilation (FGM), deprivation of liberty safeguards policy and a mental capacity policy that incorporated 'prevent' which forms part of the government's counter-terrorism strategy. The policy did not specify the required level of safeguarding training for the safeguarding lead or clinical staff. There were named leads for both children's and adult safeguarding who had undertaken safeguarding training to level 3 for adults and who attended refresher training every three years. The Royal College of Paediatrics and Child Health have published guidance (Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2014)), which sets out minimum training requirements for healthcare professionals. This guidance recommends that the named safeguarding leads attend refresher training yearly to obtain a minimum of 6 hours over three years.
- The hospital had a lead manager for safeguarding attended independent forums on safeguarding provided by the local Clinical Commissioning group (CCG). Staff we spoke with knew who the lead for safeguarding was.
- All staff received level one training in child and adult safeguarding in addition all staff who came into contact with patients or their relatives, who may be children, had level 2 child and adult safeguarding training. A flowchart had been created to assist staff in raising safeguarding concerns about children.
- Staff were regularly updated in respect of safeguarding and a quarterly report was sent out informing them of changes and training. The information supplied by the hospital showed the overall compliance for safeguarding training was 74%. Doctors showed the lowest level of compliance for Ramsay Health Care safeguarding training at 37%. However, this was due to directly employed doctors not undertaking Ramsay Health Care safeguarding training. Consultants who had been granted practising privileges at New Hall Hospital provided evidence to the service that they had attended mandatory safeguarding in their substantive roles in the NHS.

Mandatory training

- Staff we spoke with said they received regular mandatory training and were given time to complete this. Some sessions were practical and others were on-line. Separate training days were held for clinical and non-clinical staff and sessions included fire, blood transfusion, basic life support, manual handling, infection prevention and control and handwashing.
- From information provided to us by the hospital, for clinical staff, not including doctors, the overall compliance with mandatory training was 94%. Doctors, who had been granted practising privileges, had mandatory training for their roles in the NHS and provided evidence of this to the service. The service had records that confirmed this as they kept records of revalidation for each doctor. Ramsay Health Care directly employed doctors' compliance levels were the lowest at 20%. A system linked to their pay had been implemented to ensure doctors complied with mandatory training in future. The success of this system could not yet be measured as it had just been introduced.

Assessing and responding to patient risk

- There was one registered medical officer (RMO) on site at all times. RMOs were trained in advanced life support to assist if a patient became unwell. They received a full induction, and had access to a range of support including accessing services out of hours, pharmacy and patients' consultants. They told us they felt supported by the hospital staff. They said if they had been awake and busy overnight and felt they were unfit to work during the following day the agency that supplied them were able to supply an alternative RMO. They said this had not happened very often, as they were not called regularly to see patients overnight.

- There was access to an on call anaesthetist at all times. The anaesthetists were part of a local consortium that had an on call rota that ensured 24-hour cover.
- In an emergency patients were transferred to the local acute NHS trust by ambulance. We saw service level agreements (SLA) in place with the intensive care and high dependency units at the local acute NHS trust.
- Every patient had consultant led care for both day surgery and inpatient admission. The consultant undertook all post treatment reviews. Consultants were available out of hours if needed. In notes we reviewed we saw consultants had been called at night, on some occasions. The Registered Medical Officer (RMO) was available to provide medical support on a day-to-day basis and when a consultant was not in the building. However, the consultant was responsible for arranging cover for their patients if they were not going to be available. We saw letters from consultants informing the service of who to call if they were not available due to leave for example.
- An escalation procedure was in place for nursing staff to escalate concerns to the RMO and for the RMO to escalate to the patient's consultant.
- Prior to admission for day case or inpatient surgery, all patients were seen in the outpatients department. During this appointment a health questionnaire was completed which included questions about previous and current health conditions. A pre-assessment was then completed which reviewed all the patients' health information and any associated risks. Discharge planning was commenced at this appointment, to ensure patients had any equipment or support in place for when they went home following their surgery. If staff felt they were not able to ensure the safety of a patient due to their risks, a discussion with their doctor would be initiated and a decision made as to whether the patient was suitable to be admitted to the hospital for their treatment. The hospital sometimes provided care and treatment for patients who had complex needs. In these cases staff would discuss the patient's needs, pre and post - operatively, with them and their existing care staff to ensure their needs could be met and any extra support required would be in place.
- The theatre staff followed the five steps to safer surgery. This involved following the World health Organisation (WHO) surgical safety checklist before, during and after each surgical procedure. We visited anaesthetic rooms and theatres and saw the WHO surgical safety checklist completed, verbally and in writing, on each occasion. We saw that the checklist, for endoscopies, had been modified to make it more suitable for purpose. An audit of ten checklists, carried out in May 2016, showed all areas measured, apart from one, scored 100%. This made the overall compliance score 99%. The drop was attributed to one signature being omitted at the sign out stage. The action plan stated there would be a discussion with the member of staff involved and staff all reminded about the importance of completing the whole checklist process.
- Staff used the Modified Early Warning System (MEWS) to monitor patients to identify deterioration in health. This is a series of physiological observations which produce an overall score. The increase in score would mean a deterioration in a patient's condition. Staff said they would contact the resident medical officer (RMO) or the consultant directly if a MEWS score was rising and a patient was deteriorating.
- Patients were given a number to call if they had any concerns following their discharge. Staff would then be able to advise the patient of the best course of action for them.
- There was a comprehensive clinical audit programme that included care of the deteriorating patient, infection control – which included the environment and hand hygiene audits and surgical safety checklist audit.

Nursing staffing

- The hospital had systems in place that ensured the departments were staffed adequately to provide safe care and treatment of patients. The hospital had a nursing workforce strategy and quality report. Within this report, the hospital outlined clear lines of responsibilities to ensure adequate nursing staffing levels. The hospital used the Ramsay safe staffing guidance to calculate the daily nursing hours required.
- There were ten full time equivalent (FTE) registered nurses and 15 FTE operating department practitioners (ODP) and health care assistants. For each operating list there were two 'scrub' staff (one trained nurse and one theatre assist practitioner) and one health care assistant

allocated. We saw duty rotas for April, July and August 2016 that confirmed this. Staff said they were recruiting for scrub nurses but were able to fill any vacant shifts with agency and bank staff.

- Staffing levels were monitored and discussed at the daily department meeting. An electronic tool was used for planning staffing levels. Staff we spoke with said their departments were well staffed.
- Agency staff were used in some departments but they regularly worked at the hospital so were familiar with the systems and processes. There was low use of agency nurses, ODPs and healthcare assistants when compared to data we hold for other independent acute hospitals.
- One specialist nurse had been granted practising privileges. Practising privileges were granted to healthcare professionals who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration. They were responsible for managing the chemotherapy service offered on a weekly basis.
- Trained nurses registration with the Nursing and Midwifery Council was checked as required. Trained nurses had an understanding of the upcoming revalidation process and how they would demonstrate compliance with the process.

Surgical staffing

- There were 98 consultant surgeons and anaesthetists employed at New Hall Hospital with practising privileges. Practising privileges were granted to consultants who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration. Most of the consultants worked in the NHS and so received their appraisal and revalidation with the trust they worked for. Revalidation information was shared with New Hall Hospital when required. We saw staff records that confirmed appraisals and revalidation were up to date.
- There was 24 hour registered medical officer (RMO) cover at the hospital. The RMO saw patients on behalf of the consultants and could call them in at any time if necessary. The consultants were all able to get to the hospital within half an hour of being called.
- All surgery at New Hall Hospital was consultant led. This meant that consultants were responsible for their own patients 24 hours a day. It was the responsibility of each consultant, who had been granted practising privileges to work at New Hall Hospital, to cover their absences and ensure that the person appointed to cover for them had the appropriate skills and a practicing privileges agreement in place.
- Every patient was seen by their consultant and an anaesthetist pre and post operatively and they were available, on call, until the patient left the hospital.
- Patients who attended the hospital for chemotherapy would be seen their by the consultant if necessary. The consultant had been granted practising privileges in order that this could happen.

Major incident awareness and training

- There was a major incident policy in place, accessible to all staff at all times. There was a senior manager on call at all times, if a major incident was declared.
- The whole hospital was locked at night. The portering staff walked around the whole site checking windows and doors were closed and locked by 9pm.
- There were closed circuit television screens (CCTV) on the ward so staff could see who was at the door, out of hours, prior to letting them in.

Are surgery services effective?

Good

We rated effective as good because:

- Patient's needs were assessed and treatment was provided in line with legislation and using National Institute for Health and Care Excellence (NICE) guidance.
- Patient's pain and nutritional status was assessed and monitored.
- The service had policies and procedures, that included national best practice guidance, in place, regularly reviewed and available to staff at all times.
- Staff were trained to ensure they were competent to provide the care and treatment patients needed. Staff training and annual appraisal was on-going.

- Staff discussed and obtained consent to care and treatment in line with legislation and guidance.
- The hospital had Joint Advisory Group (JAG) accreditation and Endoscopy Global ratings Scale (GRS) (recognition granted to organisations that meet standards that require continuous improvement in structures, processes and outcomes) for its endoscopy service.

However:

- The medical history, and reason for admission, especially for patient who had come from another hospital, was not always clear in the patient care record and in some records the blood test results pages were not completed.

Evidence-based care and treatment

- Needs were assessed and treatment was provided in line with legislation and using National Institute for Health and Care Excellence (NICE) guidance. Staff were aware of the guidance relevant to their area of work.
- A member of staff we spoke with had written a care pathway based on the National Institute for Health and Care Excellence (NICE) guidelines for patients at risk of developing pressure ulcers. This had been introduced throughout the Ramsay group of hospitals.
- The hospital had Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its competence to deliver against the measures detailed in the endoscopy standards.
- The staff in the pre-assessment unit used evidence-based guidance for assessing risk to patients such as deep vein thrombosis, pressure ulcers and risk of falling before patients were admitted to hospital for surgical procedures. If staff found patients were at increased risk they highlighted this on the electronic booking system and the admitting ward manager received an email to alert them to the increased risk factors. This meant staff used additional precautions/ pathways in the care and treatment to reduce the risks.
- Staff in the pre-assessment unit used a recognised dementia tool to screen patients over the age of 75 years. This helped staff to ensure that patients were suitable for surgery and highlighted risks of developing confusion/delirium after the operation. If patients were not suitable, staff recorded this in the medical notes and discussed further with the anaesthetist, this meant that patients would have their care transferred to a suitable NHS hospital.

Pain relief

- Pain relief was discussed with each patient pre-operatively, in theatre and on the ward. As part of the World Health Organisation (WHO) five steps to safer surgery surgical safety checklist, pain relief that was planned to be given was discussed.
- Whilst in the recovery area pain levels were monitored and the patient was only moved to the recovery pods or ward when their pain was controlled. Post – operatively patient's pain was monitored and recorded on the modified early warning system (MEWS) chart using a scale of 1-10. Pain relief was given as required. Patients told us their pain was well managed.

Nutrition and hydration

- All patients had a nutritional risk assessment recorded to assess each patient's level of nutrition and hydration.
- Any dietary requirements were discussed with each patient and documented to ensure all staff were aware if there were any needs to be met.
- Instructions about the timescales for not eating and drinking pre-operatively were given during the patient's pre-admission visit. We saw staff check during pre-procedure checks, when the patient last ate or drank and this was recorded in the patients care record.
- There was no access to a dietician at the hospital. Staff said they would contact the local trust, with whom they had good working relationships, for advice if required.
- Feedback from patients we spoke with was very positive regarding the meals provided. The catering manager told us all chefs were trained to level three in food hygiene. There was a chef available on site from 7am to 8pm. Although there were set mealtimes there was flexibility in order to suit individual patient's needs.
- Special diets such as gluten free, vegan or cultural were catered for.

Patient outcomes

Good

Surgery

- The hospital sent data to the National Joint Registry, surgical site infection surveillance and Patient Related Outcome Measures (PROMS).
- The National Joint Registry (NJR) for England, Wales, Northern Ireland and the Isle of Man collects information on joint replacement surgery and monitors the performance of joint replacement implants. Surgeons were able to look on the registry for information about the implants they chose to use. The registry for New Hall hospital showed that in 2015 452 hip, knee and shoulder procedures were carried out with 95% of patients consenting to their information being submitted to the registry. By July 2016 260 procedures had been carried out with a 97% of patients consenting to their information being submitted to the register. This figure was in line with the national average.
- PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients. The hospitals adjusted average health gain for PROMs Hip, knee and groin hernia were all within the expected range.
- Staff in the pre-assessment unit collected information about spinal patients' condition prior to spinal surgery as part of patient outcomes measures known as PROMS, using the British Spine Registry, with consent from patients. The completed PROMS were discussed at the monthly spinal mortality and morbidity meetings to evaluate the effectiveness of surgery. The hospital had plans to expand the collection of outcome measures to include spinal injections.
- There were 22 unplanned returns to theatre between April 2015 and March 2016. There was a 24 hour on call theatre team able to respond if returns to theatre happened at night or weekends. There were no trends identified.
- In the last 12 months, there were 18 re-admissions to surgery within 28 days giving a rate of 0.30 per 100 patients. This is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the last 12 months, there were 25 unplanned transfers of inpatients to other hospitals giving a rate of 0.42 per 100 patients. This is not high when compared to a group of independent acute hospitals that submitted performance data to CQC.
- The unplanned returns to theatre, re-admissions within 28 days and unplanned transfers of inpatients to other hospitals, were investigated and discussed at theatre meetings and Medical Advisory Committee meetings.
- The provider told us all NHS patients were treated within 18 weeks of referral to New Hall. However, the patient may have been waiting for longer than that prior to their referral to New Hall meaning the 18 week target for the patient may have been breached.

Competent staff

- Practicing privileges is an authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection, including an example of where a consultant was refused practicing privileges because they were under investigation by another employer.
- All new applications for practising privileges and requests by consultants to undertake new procedures were discussed and agreed by the Medical Advisory Committee (MAC) before being approved. We saw evidence of this in minutes of MAC meetings. Once approved by the MAC, consultants were sent a formal agreement to sign to agree to work within the organisation's practising privilege policy and within the scope of practice agreed.
- Staff learning needs were identified and they were encouraged and given opportunities to develop. All staff we spoke with said they were supported and funded to undertake extra training and were given time to complete this. For example, one member of staff said they had requested to attend a training course that would be beneficial to their role. Another member of staff told us they had been approached by their manager and given the opportunity to attend the same course as they were employed in a similar role.

- Where a consultant wanted to add a procedure to their practising privileges they were required to evidence they were undertaking the procedure in another hospital before submitting the application to the MAC for approval.
- Records showed agency and bank staff undertook induction and training to ensure they were competent to work at New Hall Hospital.
- Staff received an annual appraisal. All staff we spoke with had received an appraisal in the last year and reported they had found this to be beneficial. One month prior to their appraisal they received a booklet to complete in preparation. Their comments were discussed at the appraisal meeting with their manager and objectives and training were agreed. All staff we spoke with were very positive about the appraisal process. The hospital compliance rate for appraisals was 99%.

Multidisciplinary working (in relation to this core service only)

- Staff we spoke with reported there was good multidisciplinary working both in and between departments. The hospital was a small independent hospital and many staff had worked together for a long time so knew each other well and had developed good working relationships.
- The consultants handed over any relevant information to the resident medical officer (RMO) before leaving the hospital. We were told the RMO or nursing staff contacted the consultants out of hours if necessary and found them easy to contact and approachable.
- There were service level agreements (SLA) in place with the local acute NHS trust regarding transfers of patients. The policy stated the consultant in charge of the patient should contact the local trust to arrange the transfer.
- Discharge planning was started at the pre-admission stage. This was to ensure patients and their families would be aware of any needs when they returned home. This meant appropriate equipment could be delivered to the patient's home and any short term adjustments could be made. Staff told us New Hall staff or the patient themselves would contact local community services such as the district nursing service or practice nurse if required for example to change a dressing post-operatively.
- On discharge each patient's GP and the patient, received a letter that detailed the procedure undertaken, any information the GP may need to know and any planned follow up by the service.

Seven-day services

- The surgical admissions unit (SAU) and the day case unit were open Monday to Friday from 8am to 8.30 pm and 8am to 5 pm on Saturdays. Theatres one and two were open Monday to Friday from 8 am to 8 pm and 8am to 2pm on Saturdays. Theatres three and four were open Monday to Friday from 8am to 9pm and from 8am until 2pm on Saturdays. There was a 24 hour on call service overnight, Sundays and on bank holidays.
- Nursing staff and an RMO were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of the senior management was available at all times to provide advice and support.
- There was an out of hours on call theatre rota including consultants and anaesthetists for individual patients should they need to return to theatre.
- There was an on call rota for radiologists should an urgent x-ray be required.
- Physiotherapy was available seven days a week from 8am to 8pm.
- Radiology services were available Monday to Friday from 8.30 am until 6.30 pm (8.30 pm on some occasions) and from 8.30 am on Saturdays. Finishing time depended on how many patients required X-rays.
- The sterile supplies department that included endoscopic decontamination was available Monday to Friday from 8am to 8pm.
- Pharmacy services were available Monday to Friday between 7am and 2 pm. If the RMO prescribed medicines outside of these hours nursing staff were able to access pharmacy supplies.

Access to information

- Patient care records we read were accurate and legible. However, the medical history, and reason for admission,

especially for patients who had come from another hospital, was not always clear in the patient care record and in some records the blood test results pages were not completed.

- Patient records were kept on site, or recalled from a medical records store in time for patient's outpatient appointments. We saw records were in the right place at the right time for patient's appointments and/or admission date.
- The patient's GP was informed of the patients discharge. Information included detail of the procedure that had taken place and any special instructions for the patient's on-going care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they did not take referrals from patients who lacked capacity to consent to treatment. The records we looked at all showed patients had the capacity to consent.
- Patient records showed if a patient had consented to their health being discussed with their next of kin and their GP.
- Records of patient's choices around resuscitation were not kept. This was because the hospitals pre-assessment process for routine elective surgery, considered all patients to be for resuscitation.
- The consultant gained patients consent at the pre-admission visit and again prior to the procedure being carried out. Consent was also gained for information to be included in surveillance reporting such as the National Joint Registry and the British Spine Registry.
- Staff received training in dementia, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The local Clinical Commissioning Group (CCG) provided training and all staff had access to this. From the information provided by the hospital, overall clinical staff compliance for dementia training was 66%, MCA training compliance was 74% and compliance for DoLS training was 74%. Doctor's compliance for each of these training sessions was 25%. Compliance figures were discussed at the time of our inspection, the general manager explained the figures might not be accurate, as they had recently moved to a new system of recording the data. At the time of the inspection, therefore, the service could not be assured all relevant staff had received required training.

Are surgery services caring?

Good

We rated caring as good because:

- Patient feedback about the services provided was positive. Patients said staff were caring, thoughtful and kind. Staff described times when they had been flexible to meet patient's needs.
- Patient privacy and dignity was maintained at all times.
- Patients told us confidentiality was always maintained.
- Between Aril 2015 and March 2016 there were high satisfaction scores via the NHS Friends and Family Test.
- The service gave patients detailed information about their care and treatment so they could make an informed decision about their care.

However,

- The current visiting arrangements detailed on the hospitals website and in patient information leaflets distinguishes between NHS and self-pay patients rather than patients in single rooms or shared bays, which is why the visiting hours are different. Staff said the information was going to be reviewed to make it more clear for patients.

Compassionate care

- We spoke with five patients who were very complimentary about the care and support they had received. They told us staff had been attentive to their needs and were kind and caring and that they had been treated with dignity and respect.
- We received three completed CQC comment cards. All had positive comments for example about good staff engagement, the relaxed environment and the commitment of the staff.
- The NHS Friends and Family Test scoring system was in place. The NHS Friends and Family Test (FFT) was created to help service providers understand whether

their patients were happy with the service provided, or where improvements were needed. The FFT response rate for NHS patients, at New Hall Hospital, ranged from 29 % in January 2016 to 34% in October 2015. This was lower than the England average of around 40%, for the reporting period of October 2015 to March 2016. However, the scores were higher than the England average for the same reporting period ranging from 97% to 100% satisfaction with the service.

- Staff ensured people's privacy and dignity was respected. In the NHS FFT 99% of responders said they were treated with privacy, dignity and respect.
- Patients we spoke with were very pleased with the care they received. Some of the comments made to our inspection team were:
  - "great support"
  - "caring staff"
  - "wonderful staff"
- We saw staff knocking on doors before entering patient rooms. We heard staff asking patients for their consent before carrying out a procedure or an activity with them. We heard catering staff taking time to ask patients what they would like from the menu and how they would like it cooked.

Understanding and involvement of patients and those close to them

- Each patient had a named nurse on each shift so they knew who was caring for them. We saw that visiting was between 9am and 1.30pm and 3.30pm and 9pm for private patients and between 3pm and 8 pm for NHS patients. The service told us that NHS patients were often accommodated in a shared bay. Feedback from patients in the past had indicated patient wellbeing, rest and privacy was affected by extended visiting hours. However, we were told if an NHS patient was in a single room they would be granted the same visiting hours as any other patient. The quality improvement manager told us if a patient in a shared bay requested more flexible visiting hours, staff would do everything they could to meet the request understanding that visitors are a vital part of patient wellbeing. If a carer or patient's relative who provided a caring or support role wanted to stay at the hospital this was possible, for both NHS and self- pay patients, and ensured the patient remained more relaxed and comfortable. When we asked the service about the difference in visiting hours they said they felt, on review, the information they provided on their website and in patient information leaflets did not explain the rationale behind the different visiting hours. The quality improvement manager said the way the information was written for patients, was going to be reviewed/rewritten.
- All patients completed their pre-operative assessment and health questionnaire. This was discussed with them during their outpatient assessment appointment. Patients told us they felt updated and included in their plan of care.
- Nursing and physiotherapy staff provided patient advice and individual care plans to ensure safe mobilisation following their orthopaedic or spinal surgery.
- If the patient was paying for their own treatment, costs and fees were discussed at the pre admission visit to enable the patient to make an informed decision about going ahead with the treatment. We saw documentation to confirm discussions had taken place.

Emotional support

- The service had a policy for consultants to follow when offering patients cosmetic surgery. This included referring relevant patients to local counselling services. There was also a cooling off period and time for reflection following initial consultation about their proposed procedure.
- Staff told us if a patient with learning difficulties or a person who lived in vulnerable circumstances was admitted to the hospital as an inpatient if they had a carer they would be able to come and stay with them and help care for and support them.
- The hospital ward facilitated a chemotherapy service each week. The specialist nurse took time to interact with people who used the service. Appointment times were thirty minutes apart to allow staff to spend exclusive time with each patient on arrival. Patients could attend with a friend or relative to support them.

Good

Surgery

Are surgery services responsive?

Good

We rated responsive as good because:

- The needs of patients and the local population were taken into account when planning and delivering services.
- The service gave patients information about how to make a complaint or raise a concern. There were systems in place to evaluate and investigate complaints.
- The service made reasonable adjustments for people who lived in vulnerable circumstances or had physical disabilities.
- The organisation investigated complaints thoroughly and shared any learning points across the service and the Ramsay Health Care UK as an organisation, if appropriate.

Service planning and delivery to meet the needs of local people

- The service worked hard to ensure the hospital provided services that met the needs of the local and wider South West population. We spoke with the three Clinical Commissioning Groups (CCG) who worked with the service. They all reported good working relationships with New Hall Hospital. They said the service was proactive in identifying ways to be more effective and efficient and demonstrated continual improvement and were patient focussed.
- The hospital accepted referrals from the NHS via the 'choose and book' system, self-referrals who were self-pay patients or had health insurance and from GPs. The service catered for the needs of the population of Salisbury and immediate surrounding areas. They also provided some specialist treatment to patients from further afield who could not access the treatment nearer to home for example spinal surgery.
- The manager told us the service were working closely with local CCG to develop their spinal service in order to offer services to patients in the Southwest whose local hospitals are no longer able to provide a service.
- A variety of patient satisfaction surveys were undertaken. The results helped plan future services the hospital offered. Staff told us feedback was shared with the relevant departments and if any changes to the planning of the service were needed these would be monitored for their effectiveness.

Access and flow

- Systems were in place to manage flow through the hospital. Admission times varied so that patients did not all arrive on the ward at the same time. We saw reception staff greeted patients and directed them to their rooms. Ward staff greeted and attended to the patient soon after their arrival.
- A daily meeting took place attended by a representative from each department to discuss activity in the hospital. During our inspection we attended one of the meetings and every department was represented. Each representative was given an opportunity to discuss the activity in their department and identify and resolve any concerns.
- Day surgery patients were admitted to the surgical admission unit, on arrival at the hospital, from where they went into the operating theatre. Following their procedure they were in the recovery area for initial recovery and then, depending on the procedure undertaken, into a bed or one of the eight 'pods' that contained a trolley and chair until they were ready to go home. This meant that flow through the department was well-organised and allowed patients to go home as soon as they were ready.
- In the last 12 months, the hospital reported they had cancelled 68 procedures for a non-clinical reason. All 68 patients were offered another appointment within 28 days of the cancelled appointment The reasons procedures had been cancelled included staff sickness.
- Referral to treatment (RTT) waiting times for NHS patients beginning treatments within 18 weeks of referral, were below 90% in April 2015, January and March 2016. The national target is 92%. The organisation said the lower figures were because they took patients from other providers, who had been waiting longer than 18 weeks, to help reduce their RTT.

Meeting people's individual needs

Good

Surgery

- There were disabled parking spaces near to the entrance of the hospital and a ramp to the front entrance. There was passenger lift access to each floor.
- Specialist diets were catered for including gluten free, vegan and cultural. We saw a varied menu was available and flexibility around when individual meals were served.
- Visiting times were between 9am and 1.30 pm and 3.30pm and 9pm for private patients and between 3pm and 9pm for NHS patients. The service explained this was because NHS patients were often in a shared bay and previous patient feedback had indicated that lengthy visiting hours affected patient's wellbeing. Self-pay patients were always in a side room and lengthy visiting did not affect other patients as much. Staff explained that NHS patients in shared bays who requested flexible visiting would be accommodated to meet their needs. Patient's (NHS and self-pay) carers or support staff could stay overnight to help care for the patient and make them feel settled, for example if a patient was living with dementia or had a learning disability.
- Consultants and anaesthetists saw their patients prior to surgery to discuss their procedure and expected outcomes. Physiotherapy staff saw relevant patients after their operation to ensure they started to mobilise and carry out prescribed exercises. Advice leaflets were given to patients for example; detailing exercises they needed to do and how much mobilising they should be doing and managing pain after their operation.
- Translation services were available if required. The service would identify, during the pre- assessment process, patients that needed the services. Staff would then ensure they were in place for their admission date. The hospital provided leaflets in alternative languages and/or large print as required.
- The hospital sent information about patient's procedures to their GP. Hospital staff discussed patients, who may need more care and support following discharge, with a community or practice nurse to ensure they were aware of the expected date of discharge and what further support the patient may need.
- The service made reasonable adjustments for patients that had a learning difficulty or were living with dementia. The ward had developed a dementia friendly room. The room was bright with a good view and was painted in a bright colour.
- Staff described patients they had looked after who had physical disabilities because of Multiple Sclerosis or paraplegia for example. They said they were able to work with the patients' scope of ability and provided equipment/aids and support as needed. The service had bariatric equipment (used for people classified as obese) but they did not often carry out bariatric surgery due to the anaesthetic risk.
- The service provided surgery for both NHS and privately funded patients. Priority was based on clinical need. Some spinal patients had been waiting a long time for their procedure/surgery at other hospitals that now no longer provided the service. New Hall Hospital had secured a contract for treating spinal patients and had a dedicated spinal team so prioritising spinal patients did not affect patients with other clinical needs.

Learning from complaints and concerns

- CQC had not received any complaints about the hospital between January and December 2015.
- There had been 14 complaints made to the service between April 2015 and March 2016. Documentation we saw showed the complaints had all been managed using Ramsay Healthcare complaints process. None of the complaints were referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ICAS).
- The general manager (GM) was the complaints lead for the service. There was a formal process in place for managing complaints. It included timescales for responses to the complainant.
- The senior management team (SMT) and clinical governance meetings discussed all complaints received. Heads of department (HOD) meetings discussed significant complaints as a standard agenda item. We saw a number of SMT meeting minutes, including, May 2016 which discussed a recent complaint concerning

catering. We saw a number of clinical governance meeting minutes, including, April 2016 that detailed number of complaints received and that no identified trends.

- The service said they gave patients (self-pay and NHS) and relatives the opportunity to submit complaints in a variety of ways. Patients and their significant others were encouraged to raise concerns as they arise so they can be dealt with immediately. Staff were supported to manage complaints at the point of care and resolve them if possible. If the issue could not be resolved, a member of SMT was always on hand to advise and visit the patient if required. If this did not resolve the problem the patient could make a formal complaint via the complaints procedure.
- Complaints were discussed at customer quality team meetings, held monthly. We saw the minutes for the June 2016 meeting. They showed that the service acted on all feedback to help improve the service.
- Staff were able to give examples of learning from complaints. For example, there had been a complaint regarding an aspect of the food provided by the hospital. This had been investigated and a change made. Staff reported there had not been any similar complaints since.
- There were leaflets available that informed patients how to make a complaint. We Value Your Opinion leaflets also contained a section that allowed patients to make a complaint or raise an issue. Patients were also encouraged to complete a Friends & Family questionnaire and post it into the feedback box themselves so they could give an honest answer without having to pass onto staff. Patients were also encouraged to complete the quarterly external survey and the results of this were summarised and disseminated to staff in order that learning could take place and changes made where necessary.
- New Hall also had a customer satisfaction group that met quarterly to triangulate all patient feedback from various sources including the Friends and Family Test (FFT), via the quarterly external patient satisfaction feedback and 'We Value Your Opinion' comments. The Quality Improvement lead developed a document that detailed lessons learned from patient feedback with action plans, these were shared with relevant departments.
- If a complaint was not resolved to the patient's satisfaction there was a defined process in place that included escalation to the Ramsay Healthcare regional director for the South for investigation.

Are surgery services well-led?

Good

We rated well led as good because:

- The service had a positive culture with staff reporting that the hospital was a great place to work.
- The senior management team and consultants were approachable and available to staff.
- The hospital had a clear corporate vision and strategy that staff knew about.
- The service had robust clinical governance systems in place and evidence of shared learning from incidents and complaints.
- The service had a local risk register in place and evidence of actions to reduce risks.
- The hospital had systems in place to grant and review practicing privileges for consultants working at the hospital.

However:

- The organisation took responsibility for compliance with workforce race equality standards. It was not clear if the detail could be produced at a local level. Although we saw each service recorded extensive information about equality and diversity during recruitment and as an ongoing process.

Vision and strategy for this this core service

- The hospital had a clear vision and set of values. This was a corporate vision throughout the Ramsay group called 'The Ramsay Way'. All staff we spoke with were aware of the vision and values and were able to describe aspects of it. We also saw this displayed in different areas of the hospital.

- There was a plan to increase the number of recovery pods to enable more day surgery to be carried out. Staff were aware of the plans and felt included in the development of the surgical services.
- With the recent increase in the size of the outpatients department and increase in demand for spinal work the service was looking to build on this work and become a regional centre of excellence for spinal work. The service has recruited two spinal surgeons to work with their existing team.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure for the surgical service. Service wide meetings were held which oversaw quality, audit and risk activity performance.
- The consultant who led on clinical governance described the clinical governance meetings (CGM) that took place each quarter. There was a set agenda that included each department head bringing their related facts and figures for discussion, review of clinical incidents and complaints, Friends and Family feedback and benchmarking against surgical readmissions and transfers out to the local acute hospital. We saw minutes of meetings from May 2016 that confirmed this. They said that ad hoc meetings took place in between the regular medical advisory committee (MAC) and CGM meetings to discuss a particular issue if one arose.
- Consultants, senior managers and heads of departments attended the quarterly MAC meetings. We saw from minutes that a variety of topics were discussed for example reported incidents, practising privileges and identified risks.
- We saw the hospitals internal audit programme for 2015/6. The theatre department carried out a monthly audit that included surgical safety, clinical effectiveness and peri-operative care.
- The clinical governance lead and general manager told us about national audits the service took part in which included the national joint registry (was set up in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants) and the National Patient Reported Outcome Measures (PROMs) programme.
- The pharmacy did regular audits of some parts of the services they provided, to check the quality and support improvement. For example, the pharmacist completed a medicines management audit in April 2016, a prescribing audit in June 2016 and an audit of controlled drugs in July 2016. These included a summary of the issues identified and an action plan to address these.

Leadership / culture of service related to this core service

- Staff we spoke with said their managers were easily accessible and approachable. They said they had good relationships with their managers and were able to discuss any concerns they had with them.
- Senior managers described good working relationships with the consultants and the MAC. They also felt their good working relationship with the local acute hospital was very valuable in helping to provide good patient care.
- Consultants we spoke with were very positive about staff of all grades who worked at New Hall Hospital and described good working relationships.
- Each department had a head of department who reported to Matron, who in turn reported to the general manager.
- Staff told us they felt their heads of department were very approachable. Staff spoke highly of the theatre manager who in turn spoke very highly of the theatre team.
- For self-paying patients, discussions about fees took place at the pre-admission outpatient's appointment, at which terms and conditions were agreed. The agreed package of payment covered all eventualities including post-operative care and support.

Equality and diversity

- 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 £200,000 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.
- We discussed WRES with the hospital general manager and matron. The hospital manager knew that the

organisation, as a provider of NHS health care, had a duty to be compliant in line with its standard contract obligations and was able to show us a very detailed Ramsay Health care UK Equality Duty and Actions report 2016. There was no report at a local level detailing New Hall Hospitals equality and diversity information. However, it is noted that due to the small numbers of staff working at independent hospitals this may mean it is difficult to draw strong conclusions about the equality and diversity performance from these hospitals.

- During our inspection we only spoke with one person with a BME background. They were happy in their work and felt supported by the hospital team.

Public and staff engagement

- The general public were invited to open events held at the hospital. The events showcased the types of treatments available at the hospital and often gave people the chance to have a one to one discussion with staff about particular procedures that might be suitable for them. Staff said these events were popular and were a way to engage the local population.
- Staff said they felt engaged with the service. They felt they were consulted with and kept up to date with any changes to the service by face- to- face conversation, emails, news-letters or during team meetings.
- Staff told us they had light-hearted competitions between departments that enhanced team working.
- The hospital recognised long service. Staff were awarded lapel pins for every five years of service and their annual leave entitlement was increased by one day every five years. They were also given a monetary gift after every five years of service. If more than five staff in one quarter received a long service award, a special meal was provided for them.

Innovation, improvement and sustainability

- The hospital was awaiting the introduction of electronic care records in the near future. Managers acknowledged that this would solve some of the issues around separate consultants' notes for private patients and ensure all records were available and easy to read. The bookings manager had been involved with the planning stages and had identified 'super users' to help implement and trouble shoot once the system was introduced.
- The hospital had improved the services it provided in endoscopy. It had recently been approved for vacuum packaging of sterile equipment meaning the equipment could be stored for 30 days without being re-sterilised instead of seven days.

Good

Outpatients and diagnostic imaging

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

Information about the service

New Hall hospital is an independent hospital, which opened in 1980 and forms part of the Ramsay Health Care UK group. The hospital is situated on the outskirts of Salisbury. The hospital accepts referrals from GPs and local NHS trusts either as private patients or as NHS funded patients via the NHS e-Referral Service. New Hall is a recognised NHS Treatment Centre under the extended choice network, which allows patients to choose referral to any recognised NHS treatment facility including those in the private sector.

Between April 2015 and March 2016, the outpatient department held 29,876 appointments of which 67% were NHS funded appointments and 33% were private appointments. These included 8,949 new referrals and 20,927 follow up appointments.

The hospital also provides outpatient appointments for NHS patients for spinal services in Poole and Dorchester hospitals and at Blandford clinic for general and orthopaedic services. We did not inspect any of these locations during our inspection of New Hall Hospital. The hospital does not treat children and young people under the age of 18 years.

The outpatient department is part of a recent extensive refurbishment, which also included a new spinal theatre complex and a day case unit. The project was completed in June 2016. The services include a variety specialities including audiology, cardiology, gastroenterology, orthopaedics and urology, the pre-assessment clinic, and have nine consulting rooms, a phlebotomy (blood taking) room and two treatment rooms. The department offer outpatient services six days a week and is open from 8am to 8pm Monday to Friday and on Saturday from 8am to 1pm.

Between August 2015 and end of July 2016 the imaging department facilitated 4992 plain film X-rays, 1766 ultrasound examinations and 773 fluoroscopy procedures (a study using a continuous x-ray beam passing through the body part being examined). In the same period the hospital facilitated 2387 Magnetic Resonance Imaging (MRI) scans and 407 Computerised Tomography (CT) scans using the visiting mobile scanner.. The department is open five days a week from 8.30am to 6.30pm (8.30pm on some days) and two Saturdays a month. In addition, the department offers a 24 hour on call service for theatre/ ward patients.

The physiotherapy outpatient services include musculoskeletal disorders (MSK) and post-operative rehabilitation following orthopaedic surgery. The department treated 959 day patients, 920 inpatients and 4170 outpatients. It is open five days a week from 08.30 am to 8pm.

We inspected the hospital on August 9 and 10 2016 and this was an announced inspection.

We spoke with eight patients and their relatives (two) or carer and a range of staff including staff nurses, resident medical officer, consultants, radiologists, radiographers, bookings administrators, medical secretaries and physiotherapists.

We met with the managers from the outpatient department, radiology department, physiotherapy department and bookings and administration. Prior to and following our inspection, we reviewed performance information about the hospital. Data was sent to us by the

Good

Outpatients and diagnostic imaging

hospital and we also obtained information from public bodies such as Healthwatch, who hold information about health care organisations, and from patients who visit the hospital for medical appointments.

Summary of findings

Overall we rated the New Hall outpatient and diagnostic services as good because:

- Staff were aware of their responsibilities to report incidents and there was a good incident reporting culture amongst staff.
- Staff were generally up-to-date with annual appraisals and mandatory training. We saw comprehensive training folders confirming staff competencies.
- Equipment was maintained and serviced regularly and staff took prompt and appropriate action to ensure compliance.
- The radiology department complied with Ionising Radiation (Medical Exposure) Regulations (2000)
- There were systems in place to give patients information about what to do if they felt unwell or had questions about their care and treatment .
- There was an effective on call rota for imaging staff that ensured emergency x-rays could take place out of hours and processes in place to transfer patients who needed emergency scans when the mobile scanner was not at the hospital.
- We observed staff obtain consent before treatment interventions although staff did not always document this.
- We observed caring and kind interactions between staff and patients.
- The service had good provision of chaperone services. Patients told us staff always treated them with dignity and respect and that confidentiality was always upheld.
- Patients were involved when arranging appointments to suit their needs and circumstances.
- The service gave patients extensive information about their care and treatment so they could make an informed decision about their care.

Good

Outpatients and diagnostic imaging

- Referral to treatment time was better than the targets and meant the hospital saw and treated 100% of patients within 18 weeks from referral.
- The hospital had a complaint policy and handled complaints in a timely manner. There was evidence the service made changes because of lessons learnt from complaints.
- The hospital had a clear corporate vision and strategy that staff were knowledgeable about.
- There was a robust clinical governance framework and evidence of shared learning from incidents and there were local risk registers and evidence of actions to mitigate risks.
- There were systems in place to review and grant practicing privileges for consultants working at the hospital.
- There was a resident medical officer on duty 24 hours a day who was competent to deal with clinical emergencies.
- There was a culture of empowering staff to engage with the development of departmental clinical vision and identified actions to achieve this.

However:

- Staff did not always ensure daily cleaning of equipment and there were no systems to monitor and audit this.
- The compliance rate for directly employed consultants completing mandatory training was very low.
- The imaging department had a sink with no hot water and soap which did not comply with recommendations for hand hygiene although other sinks were available for staff to use.
- The environment in the physiotherapy department was very cramped and cluttered. This meant that efficient cleaning was difficult.
- There was no system in place to monitor the use of prescriptions in the outpatient department in order to prevent theft or misuse.
- The hospital did not have sufficient assurance about the maintenance and water quality in a hydro pool, which was in a nearby NHS hospital, to ensure it was safe for patients to use.
- The outpatient and radiology department used the World Health Organisation (WHO) five steps to safer surgery surgical checklist for patients having minor or invasive procedures however; neither department audited the use of these.
- The imaging department had corporate standard operational standards for all procedures but they did not have local protocols although there was a plan to produce these in line with the recommendations set out in the National Safety Standards for Invasive Procedures, which were published in September 2015.
- The service did not collect patient outcome data or evaluate the effectiveness of care and treatment delivered.
- Consultants did not consistently issue a discharge letter to patients. This meant that in an emergency other healthcare professionals would not have access to information about a patient's recent health.
- The hospital did not consistently assess patient's communication needs and did not comply with Access to Information Standards.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm.

We rated safety of the outpatient and diagnostic imaging services as requires improvement because:

- Staff did not always ensure daily cleaning of equipment and there were no systems to monitor and audit this.
- The compliance rate for directly employed consultants completing mandatory training was very low.
- The imaging department had a sink with no hot water and soap which did not comply with recommendations for hand hygiene although other sinks were available for staff to use.
- The environment in the physiotherapy department was very cramped and cluttered. This meant that efficient cleaning was difficult.
- There was no system in place to monitor the use of prescriptions in the outpatient department in order to prevent theft or misuse.
- The hospital did not have sufficient assurance about the maintenance and water quality in a hydro pool at a nearby NHS hospital, to ensure it was safe for patients to use.
- The outpatient and radiology department used the World Health Organisation (WHO) five steps to safer surgery surgical checklist for patients having minor or invasive procedures however; neither department audited the use of these.

However:

- Staff were aware of their responsibilities to report incidents and there was a good incident reporting culture amongst staff.
- There were comprehensive training folders for nursing and allied healthcare staff that demonstrated compliance with mandatory training.
- Equipment was maintained and serviced regularly and staff took prompt and appropriate action to ensure compliance.
- The imaging department complied with Ionising Radiation (Medical Exposure) Regulations (2000).
- There were systems in place to give patients information about what to do if they felt unwell or had questions about their care and treatment.

Incidents

- The hospital reported eight serious incidents in the period from April 2015 to March 2016; this was higher than expected when compared to a similar group of independent acute hospitals. There was one serious incident reported in the clinical governance meeting minutes in April 2016 (removal of bony lump). The procedure was more involved than expected and should have been carried out as day surgery. There was another reported in the heads of department meeting minutes in May 2016 concerned with a patient who had fallen outside the outpatient department. We reviewed the investigation of one of the incidents, and found a thorough investigation and evidence of learning and change of practice to improve care.
- There were systems in place to record incidents, concerns or near misses. Staff understood their responsibilities to raise concerns and reported incidents using the hospital's electronic incident reporting system. Staff told us the system was easy to use and were able to show us the incident reporting policy, available on the intranet. In the period from April 2015 to March 2016, the outpatient and radiology departments had reported 11 clinical incidents which was one percent of all clinical incidents reported and is less than in other similar independent acute hospitals. In the imaging department there had been no incidents of greater than intended exposure to ionised radiation.
- There was a robust and thorough process in place to investigate and review processes following clinical incidents. One of the department managers was also responsible for reviewing the quality of care and treatment delivered at the hospital. They produced thorough reports and discussed these in clinical governance meetings and heads of department

meetings. Learning was cascaded in different ways such as via department meeting, by monthly 'bite size bulletins' and displays on 'quality boards' where important information was shared with staff.

- We reviewed an investigation into one of the serious incidents that occurred in the period from April 2015 to March 2016. The investigation was thorough and highlighted areas for improvement to practice with actions for allocated staff to complete within a given period. The report also identified how learning should be shared across the department and the hospital as a whole.
- The outpatient department manager and the physiotherapy department manager told us about 'Ramsay networks' where new practice or learning was shared across different Ramsay hospitals. The manager from the radiology department attended regular meetings with radiology departments from other Ramsay hospitals.
- There was a 'radiology lessons learnt report' produced to ensure learning across Ramsay hospitals in relation to review and feedback of incidents, complaints and audits. Staff in the imaging department shared and discussed the reports in the radiology department meetings at New Hall.

Duty of Candour

- Staff demonstrated awareness of Duty of Candour, understood the principles of openness and were aware of when to apply Duty of Candour and what this involved. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the provider to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. We saw evidence that Duty of Candour had been applied in investigations of incidents in other departments of the hospital.

Mandatory training

- Staff received effective mandatory training in line with corporate polices. However, there was a problem with the electronic system to monitor compliance; all managers we spoke with confirmed 100% compliance at the time of inspection, although the compliance data we obtained prior to the inspection demonstrated a lower compliance rate. All staff we spoke with also stated they were up to date with mandatory training. The data we obtained prior to the inspection was for the period from October to December 2015.
- Mandatory training was delivered via a practical day combined with e-learning. Overall compliance was more than 84% for the outpatient department, radiology and physiotherapy departments but for the consultants overall compliance rate was only 17%, however consultants working under practising privileges also received mandatory training in their NHS jobs.
- The practical session included topics such as fire safety, blood transfusion, basic life support, manual handling and infection control (hand washing, health-care associated infections and the chain of infection). The reported rate of compliance was varied: outpatient department = 88%, pre-assessment unit = 50% and physiotherapy = 66% and for doctors the rate was only 20%.
- We discussed the low compliance rate for doctors with the general manager who said it had been agreed that mandatory training, for directly employed consultants was to be linked to their pay review. In future if these consultants were not fully compliant with their mandatory training, they would not get a pay rise. The directly employed consultants had been given training dates at weekends and access to online training.
- The e-learning focussed on training about dementia, mental capacity act and associated deprivation of liberty. Compliance with the e-learning modules were better than for the face-to-face session as follows outpatient department and pre-assessment unit = 91% but only 50% had completed dementia training; physiotherapy = 72% and only 25% of doctors had completed the e-learning. The hospital had a corporate policy called 'Facility Rules; which held information about the granting of practising privileges. The facility rules was compiled of rules or general conditions of granting practising privileges, to ensure consultants working under practising privileges were safe to do so. Included were rules about 'attending and when reasonably so required participate in other training programmes as may be organised and held at the

facility. (Rule 240.28). The service had recently introduced a system that linked consultants pay review to completion of mandatory training to increase the compliance levels.

- We saw comprehensive training folders for all staff in the outpatient department and in radiology, which provided easy access for staff and managers to review compliance and to form part of annual appraisals.
- The hospital had a contract agreement with -an external provider to ensure all registered medical officers (RMO) were up-to-date with mandatory training including advanced life support and infection control. However, this did not involve training on manual handling.

Cleanliness, infection control and hygiene

- The hospital did not always have reliable systems in place to prevent and protect people from hospital-associated infections. Clinical staff told us they were responsible for cleaning equipment and surfaces in clinical areas and treatment rooms. However, we found dust on apron holders and on an ECG machine, and green stickers on trolleys that stated the last date of cleaning was 5 August, which demonstrated this was not done daily in the outpatient and physiotherapy departments. The matron told us that trolleys are cleaned before and after each use and therefore not part of daily cleaning schedules.
- Comments from patients in the radiology department included how clean the department always looked and in a patient-led assessment of the care environment (PLACE), the hospital scored 98% for cleanliness, which equalled the national average. In the radiology department, there was a system in place to ensure clinical staff carried out daily or weekly cleaning procedures of equipment and surfaces that the general domestic staff were not responsible for cleaning.
- Processes were in place to protect patients from hospital-acquired infections and the hospital had a good record for infection control. There had been no reports of Clostridium difficile or Methicillin-resistant Staphylococcus aureus (MRSA) from April 2015 to March 2016. There were systems in place to ensure the service screened patients for Methicillin-resistant Staphylococcus aureus (MRSA) in the pre-assessment clinic.
- Nurses wore clean uniforms, had their hair tied back and did not wear jewellery. We saw one nurse wearing a belt with a buckle and we were concerned that belts could not be adequately laundered. The Royal College of Nursing (2013) recommend that uniforms are laundered at 60 degrees Celsius and that fabric containing Lycra may not endure thermal disinfection processes. We reviewed the corporate uniform policy and found that wearing belts was allowed if laundered regularly and if the buckle was washed in hot, soapy water daily to prevent the spread of infection. However, it was not clear how this would be monitored.
- The hospital had a 'bare below elbows' policy and while most staff observed this we also saw a number of consultants wearing long-sleeved shirts and ties that were not 'tucked in'. We saw that clinical staff washed and gelled their hands appropriately and reception staff politely reminded patients and relatives to gel their hands on arrival.
- There were systems in place to monitor implementation of safety systems, processes and practices. There was a comprehensive audit calendar to monitor compliance with infection control and prevention procedures such as hand hygiene. We reviewed some of the audits and generally found that compliance was good. However, we saw a member of the catering department wearing false nails, which did not comply with best practice.
- In the imaging department, there were not adequate facilities for staff to wash their hands as recommended in national guidelines. The sink in one of the screening rooms did not have lever taps that staff could turn on and off using elbows. A hand hygiene audit highlighted this in May 2016 and an action to replace the sink agreed. However, when we visited the department this action was still outstanding. We spoke with senior management about this who told us that the sinks had been replaced but with the wrong kind, a requisition was in place for replacements
- Consultation and treatment rooms had examination couches with paper covers, access to personal protective equipment (aprons and gloves) in all rooms, access to hand wash facilities and paper towels for drying of the hands. Each room had appropriate general and clinical waste bins as well as sharps bins for the safe

disposal of sharps. The chairs had covers that could be easily wiped. We saw that staff wiped the couches between patients but we also saw a consultation where staff did not cover the couch as outlined in their policy.

- The hospital took precautions in the outpatients, physiotherapy department and imaging department, when seeing people with suspected communicable disease such as tuberculosis. These precautions included asking for advice from the infection control nurse and deep cleaning of the environment following the appointment If a patient had a confirmed communicable disease, the hospital would defer their appointment to such a time where they would no longer be infectious. The hospital had extensive infection control and prevention corporate policies in place for staff to access information and there was an appointed lead for infection control to support staff with any queries.

Environment and equipment

- The hospital was in an old listed building, which was charming but not purpose built and therefore presented some challenges to the design, maintenance and use of facilities. In a patient-led assessment of the care environment (PLACE), the hospital scored 88% for the condition, appearance and maintenance of the building and outside areas. This was slightly less than the national average of 92%.
- The outpatient department was in the newly renovated stable block and as such it was not a purposely-designed building. The department was bright and well maintained. The consultation rooms consisted of two rooms with an interconnecting door. There was a lock in the room used for clinical examinations to avoid accidental entry during examinations and a sign to indicate that the rooms were in use.
- The corridors, waiting areas and consultation rooms all had newly fitted carpets, however the examination rooms, treatment rooms and sluice rooms had vinyl flooring that could be easily cleaned. The carpets appeared clean and had no visible stains. The environment complied with recommendations about natural light, bright rooms and furniture however, the Department of Health: Health Building Note 00-04 suggests that use of soft coverings, such as thick carpet, should be avoided. This was on the hospital's risk register to ensure on going monitoring of the condition of the carpets.
- The physiotherapy department was located in the older main building and showed evidence of needing some redecorating; we saw stained walls around a sink in a treatment room. There were no curtains for patients who may need to undress for their treatment or examination.
- The department consisted of two examination/ treatment rooms and a gym. However, all the rooms appeared small with little room to manoeuvre around the examination couch and other equipment stored in the room. The gym had a number of large pieces of equipment such as exercise bike, rails, and couches and appeared to be very cramped. We spoke with staff about this and it seemed they were used to working in the spaces and did not find it compromised their work. The hospital had plans to relocate the physiotherapy department to a larger department in the near future.
- There was a storeroom in the physiotherapy department, which was tidy, but had boxes with consumables stored in plastic boxes on the floor. Whilst we did not find visible dirt or dust, having boxes stored on the floor made cleaning difficult. The physiotherapy manager only cleaned the storeroom, there did not appear to be any set schedule to ensure that regular cleaning of surfaces, and floors took place.
- We located a laser in the physiotherapy department. We were concerned there were not sufficient risk assessments and mitigating actions to ensure staff could administer the laser treatment safely. We escalated this to senior management and the general manager who immediately took action and removed it from the department. However, staff had not used the laser treatment for five years and the hospital chose to remove this as a treatment option.
- The imaging department was in the main building. The waiting area did not have any natural light but it was spacious, clean and well- maintained; patients in the radiology department had access to two disabled toilet facilities. There were three changing cubicles with curtains to screen off. There was a room used for

ultrasound examinations and a general x-ray room, which was also used for fluoroscopy (a study using a continuous x-ray beam passing through the body part being examined).

- There were systems and processes in place to ensure equipment was safe and maintained. We saw 'provision and use work equipment regulation' registers, which demonstrated that equipment was serviced and maintained regularly via a service level agreement (SLA) with an external medical physics provider. The registers demonstrated compliance although managers told us there was a potential delay with the servicing of equipment that required twice yearly servicing. This delay was because of the annual review of the SLA. Managers took immediate action when service of equipment was due and highlighted this with the operations manager and with the company providing the service.
- We saw the audit carried out by the radiation protection advisor in the imaging department in February 2016; the department was 'nearly fully compliant with only a few minor improvements necessary'. The actions were all completed and signed off.
- A Ramsay Health Care engineer' maintained and serviced all non-medical equipment (including annual portable appliance testing of electrical appliances). The operations manager held the register but we saw records to confirm this in the departments.
- The manager in the imaging department held records to confirm that equipment was maintained and serviced regularly. We saw equipment logs including service level agreements for maintenance of equipment. There were risk assessments and local rules for all the imaging equipment at the hospital. Local rules are a summary of instructions for staff to restrict exposure to radiation. This conformed to specifications in the Ionising Radiation (Medical Exposure) Regulation (2000). We saw corporate standard operating procedures to guide staff caring for patients who attended for computerised tomography (CT) or magnetic resonance imaging (MRI) scans in the mobile scanning unit.
- The hospital had arrangements for managing waste to keep people safe. There were clinical waste bins and domestic waste bins in all rooms and staff segregated waste appropriately. There were sharp bins in rooms as required and these were not overfilled.
- We spoke with medical secretaries and bookings administrators who worked in a new purpose built office block, which offered them spacious and light working environment.

Medicines

- The hospital had a pharmacy that was staffed from 8:00 until 15:00 Monday and Thursday and from 08:00 until 14:30 Tuesday, Wednesday and Friday. A pharmacist was available in the hospital for four hours Monday to Friday. The hospital had arrangements for staff to access the pharmacy out of hours if needed. Staff gave patients prescriptions for medicines if needed. Patients took these to a community pharmacy to be dispensed. A small supply of take home packs of antibiotics was available for patients to take home if the doctor prescribed these.
- The pharmacy provided a weekly topping up service for stock medicines and checked expiry dates. Staff made additional orders if needed. Systems were in place to identify any medicines with a short expiry date, so pharmacy staff could replace them at the appropriate time. This meant the correct medicines were available for staff to use.
- Medicines were stored in a way that kept people safe from avoidable harm. Medicines were stored securely in locked cupboards and only registered nurses had access to the keys. There were systems in place for monitoring the temperature of both the clinical room, where they were stored, and of the fridge temperature; the departments kept records for auditing. Registered staff knew how to report if temperatures were outside normal limits. All medicines we checked were in date; there were no controlled drugs in the outpatient department, radiology or physiotherapy department.
- Emergency medicines and equipment were available. Staff checked the sealed emergency trolley daily and the medicines weekly to make sure they were always safe for use. The pharmacy kept

Good

Outpatients and diagnostic imaging

- We reviewed five sets of medical notes (chosen at random from patients who had attended the hospital in the last six months) including medicine prescription charts and found that the doctor did not always document the stop date for medicine prescriptions.
- In one set of notes, we found that a patient's severe allergy to an antibiotic was not recorded in all of the places it should have been and therefore there was a risk that the patient could be prescribed and given medicine, they were allergic to. We reviewed the clinical summary report and found that this was identified as a trend in reported incidents because of this an organisational learning/action plan was identified to reduce the risk of this happening again.
- Outpatient prescriptions were stored securely. Carbon copies of private prescriptions were kept and photocopies of NHS prescriptions issued, so staff could see what had been prescribed. However, there was no system in place to log and monitor the usage of prescriptions to allow auditing and safe prescribing practice. This was also not clear from the corporate medicines management policy.
- Before any scanning took place in the mobile scanner unit staff collected emergency boxes, containing medicines to be used in case of a severe allergic reaction, from the radiology department. There was a risk of an allergic reaction due to the intravenous injection of contrast medium. Staff knew the signs of an allergic reaction and knew how to summon help in medical emergencies. The department had a designated phone line, which was only used for CT, MRI and fire emergencies. In case of a medical emergency in the mobile scanner unit the receptionist would activate the emergency crash call.
- We observed a patient attend for a change of wound dressing following an operation. The patient complained of being in pain and staff took time to discuss effective pain management including dosage and frequency.

Records

- Records about individuals care were managed in a way that kept people safe. The hospital managed medical notes differently for private and NHS patients. For NHS patients all records were held together whereas for private patients, the consultant's notes were kept in a separate file. We reviewed ten sets of medical notes for patients attending the outpatient department for either a first appointment or a follow-up appointment. The recording of care and treatment largely complied with the hospital's corporate policy however the notes were not always easy to read. All notes, we reviewed, were signed and dated. Managers audited medical records quarterly as part of a comprehensive audit calendar.
- Medical records were stored securely in a new purpose built office building. It was the responsibility of the medical secretary to ensure medical records were available for appointments in the outpatient department. The records were in locked cupboards and the office was locked out of hours and the keys taken to the main reception desk to ensure only designated people could access notes at all times if required.
- The hospital had introduced the use of an electronic patient portal for patients to complete medical questionnaires and registration forms online. The system was safe as the patients had to create their own passwords and the data was encrypted. The hospital held an ISO 27001 accreditation for information security, which meant there was a high standard of information security that managers audited regularly.
- In the imaging department, staff scanned in and attached referrals and checklists to the image using an electronic picture archiving and communications system. A paper copy was filed in the patient's notes. This meant the radiologist had access to all information when reporting on images or scans. Staff told us the electronic system could be a little slow at times but a system upgrade was due.

Safeguarding

- The hospital had systems and processes in place to safeguard adults and visiting children. There were no safeguarding concerns reported to the CQC in the period from April 2015 to March 2016. The hospital had a safeguarding adult's policy, deprivation of liberty safeguards policy and a mental capacity policy that incorporated 'prevent' which forms part of the government's counter-terrorism strategy. The policy did not specify the required level of safeguarding training for the safeguarding lead or clinical staff. There were named leads for both children's and adult safeguarding who had undertaken safeguarding training to level 3 for

adults and who attended refresher training every three years. The Royal College of Paediatrics and Child Health have published guidance (Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2014)), which sets out minimum training requirements for healthcare professionals. This guidance recommends that the named safeguarding leads attend refresher training yearly to obtain a minimum of 6 hours over three years.

- Staff received training in adult safeguarding and knew how to raise a safeguarding concern with senior managers. Safeguarding training was in the process of moving from a face-to-face session to an online e-learning format. Compliance with safeguarding training in December 2015 was 84% in the outpatients department and in the imaging department. In the physiotherapy department, compliance was 72 %, however compliance for directly employed consultants was only 37%. A system that linked training compliance to their pay had recently been introduced. Access to e-learning and training sessions at weekends, to increase compliance, had also been introduced. Consultants working under practising privileges received mandatory training in their NHS jobs and provided evidence of this to the service as required. We saw staff files that confirmed this. Registered healthcare professionals such as consultants, radiologist, nurses and radiographers had undertaken level two safeguarding training and healthcare assistants and other support staff had undertaken level one safeguarding training.
- There was a corporate policy for safeguarding of children and young persons and the hospital had a named lead, who had received training a level 3 in children's safeguarding. Staff had easy access to information and flow charts if they suspected visiting children were vulnerable.
- There were systems in place in the imaging department to ensure the right patient had the right scan at the right time. Staff used a 'pause and check' approach to ensure the correct patient identity, the right scan/image to be performed, authorised referrer and that there was sufficient clinical information to justify exposure to ionised radiation. There were additional safety checks for female patients of childbearing age.
- In the physiotherapy department, we saw that staff obtained a thorough history of the patient's health and mobility in order to help them plan an effective treatment plan.
- Staff in the outpatient department and radiology department used the World Health Organisation (WHO) five steps to safer surgery surgical checklist when carrying out minor or invasive procedures. The WHO checklist is a nationally recognised tool to enhance safer surgery. However, neither department audited compliance with the use of the checklist.

Assessing and responding to patient risk

- Staff identified and responded appropriately to changing risks in patients who used the services. The outpatient department had a resuscitation trolley on the upper floor of the building. Staff checked the trolley daily and records confirmed this. The outpatient department manager had highlighted a potential risk in the event a patient suffered a cardiac arrest on the lower floor of the building, as there was no resuscitation trolley on the lower floor. This was registered on the risk register and a practical exercise had been carried out to ensure staff had access to resuscitation equipment in a timely manner. The lower floor had an automated external defibrillator and emergency oxygen and mask readily available.
- There was an automated defibrillator outside the x-ray room. In the event of a medical emergency, the staff would call/page the resident medical officer and staff from the nearby inpatient ward would bring the emergency resuscitation trolley to the radiology department.
- Staff we spoke with could describe what to do if a patient became unwell, could describe the procedure for summoning emergency help, and knew where their nearest resuscitation equipment was.
- Staff gave patients a 'keep in touch' (KIT) card when they were discharged from hospital, with information of whom and how to contact the hospital if they had any concerns or queries. We discussed a call with staff in the outpatient department, who was the first point of contact, about how they triaged and processed such telephone calls from patients. The staff explained about a call that had come in that morning from a patient who was concerned following discharge after day case

surgery. The staff arranged an appointment for the patient to return to the outpatient department for further assessment the same afternoon. Staff also explained that sometimes they would advise the patient to go directly to the emergency department at a nearby NHS hospital if they thought the condition was serious or potentially life threatening. There were processes in place to ensure staff recorded these telephone calls in patient's notes and standard operating procedures for triaging and processing calls for staff to follow.

- We observed a nurse-led wound dressing appointment. The nurse obtained verbal consent, used appropriate aseptic technique, and assessed the patient's wound. They checked the patient's general well-being as there was a possibility that the wound was infected. The nurse escalated this to the resident medical officer (RMO) on duty who assessed the wound and recommended the patient should come back the following day for the consultant to assess and review the wound. The nurse spoke with the patient and their relative to ensure they were happy with the arrangement and made an appointment for the following day. Staff completed all care records and documented decisions at the time of the consultation. We asked the RMO if they could prescribe medication for private and NHS patients in the outpatient department to which they replied that they could but it would always be preferable if the consultant treated the patient.
- There were strict criteria about which minor surgical procedures could safely be carried out in the outpatient department and staff discussed an incident were the procedure had exceeded these criteria which had resulted in an investigation into the incident and actions put in place to ensure it would not happen again.
- Risk assessments were carried out for people who used the hospital. Staff in the pre-assessment clinic undertook screening for venous thromboembolism for surgical patients prior to admission. The compliance rate for screening was greater than 95%. They also completed other risk assessments such as pressure ulcer risk assessment using a recognised assessment tool; staff explained that if the score was greater than 15 it meant the patient was at an increased risk of developing a pressure sore. If patients were at risk staff took extra care to implement additional care pathways, ensure advanced notification on the electronic appointment system and they emailed the departments the patient would visit during their treatment.
- The imaging department had access to a radiation protection advisor (RPA) via a service level agreement with a London hospital. Staff told us it was easy to get hold of the RPA for advice. They also visited the hospital at least once a year to carry annual audits. The RPA was legally responsible for ensuring maintenance of the quality assurance testing, patient dose audits and staff dose audits and we saw records to demonstrate these were all up to date and within acceptable ranges. There had been no recent issues with ionised radiation dosages greater than intended. The hospital had appointed one of the radiographers as a local radiation protection supervisor in line with the Ionising Radiation (Medical Exposure) Regulations (2000). Their responsibility included providing advice locally and to carry out all audits in a timely manner.
- In the imaging department, there were risk assessments for patients having different screening procedures including the mobile CT and MRI scanner. The risk assessment included information about the general health, any metal implants and mobility issues in relation to accessing the mobile scanner.
- There were effective systems in place to ensure that only authorised clinicians could sign referrals for imaging and protocols to ensure unnecessary repeated exposure. Both X-ray rooms had protective personal equipment such as lead aprons and gloves. There was adequate signage in place to notify others of ionising radiation and there was restricted access, by key pads on doors, to avoid accidental entry during screening.
- The hospital followed the 'hydro pool operational policy (August 2015) from the local NHS hospital as a service level agreement, to provide opportunities for patients, who had spinal surgery, to extend their physiotherapy using a hydro pool at a nearby NHS hospital. The hospital had individual referral forms/risk assessments for patients using the pool and a designated physiotherapist and a physiotherapy assistant from New Hall accompanied them. The hospital had reviewed risks to patients using the hydro pool (August 2016); risks were considered to be low and reduced from 'moderate' from the previous risk assessment although

it was not clear what mitigating actions had been implemented to lower the risks to patients. We asked how the hospital was assured about the maintenance of the hydro pool such as the water quality; the hospital did not have this information and could not provide assurance that this was monitored.

- Staff in the outpatients, radiology and physiotherapy departments were aware of actions to take if a patient became unwell during an appointment including when and how to call the RMO or call for immediate assistance in a medical emergency.
- We asked about risks assessments for children, who accompanied adults attending appointments, to ensure it was a safe environment. Booking administrators sent out a leaflet to all patients informing them that the hospital did not have facilities to look after children during consultations. Staff told us they were up-to-date with children's safeguarding training and the RMO had advanced paediatric life support training in the event of a medical emergency involving a child.

Nursing staffing and allied health care professionals

- The hospital had systems in place that ensured the departments were staffed adequately to provide safe care and treatment of patients. The hospital had a nursing workforce strategy and quality report. Within this report, the hospital outlined clear lines of responsibilities to ensure adequate nursing staffing levels. The report acknowledged there was a need to recruit more staff in view of the extended capacity to hold clinics in the outpatient department and the hospital had participated in corporate recruitment drives to appoint nurses.
- There were five full time equivalent (FTE) registered nurses and 1.1 FTE health care assistants employed to work in the outpatient department. There was currently one 0.6 FTE registered nurse vacancy and a vacancy for a healthcare assistant. In the period from April 2015 to March 2016, there was a staff turnover of 13%; this is not high when compared to other independent acute hospital we hold this type of data for.
- There was a low usage of bank staff and no usage of agency staff in the outpatient department, radiology department and in the physiotherapy department during the period from April 2015 to March 2016. The bank nurses were from an established pool of bank nurses who received equal training and appraisals as permanent staff. We reviewed the training folder of a bank nurse who was still within her induction period; there was evidence of comprehensive training and support from buddy/mentor and regular reviews with the outpatient department manager. This meant that the bank staff felt included in the teamwork ethos of the department.
- We reviewed the electronic staff rostering system used in the outpatient department. The outpatient department manager stated it was a versatile tool and worked well in their department. The system allowed managers to run reports analysing the skill mix and numbers of staff rostered to work on a rota; the system produced graphic alerts if rotas were covered adequately (blue sky and sunshine) or 'lightning' image if the rota was not meeting requirements. The manager planned rotas six weeks in advance and these were authorised by the matron before publishing. We looked at rotas covering the month of August and they showed the department was adequately staffed with no gaps to be covered with bank staff.
- The outpatient department used two bank nurses regularly who were familiar with the different clinics. We asked how clinics may be affected if staff phoned in sick and a replacement from own staff or the bank could not cover the shift. The manager stated they would cancel clinics if they could not run safely. They would contact patients booked in to rearrange their appointment.
- The hospital employed allied healthcare professionals; there were four radiographers in the imaging department and two regular bank radiographers that knew the department well. The department had a rota to ensure coverage every evening and at weekends.
- The physiotherapy department had five senior physiotherapists and two physiotherapy assistants. The assistants had comprehensive training and support from physiotherapists in the department and the manager assessed their competence before assigning them individual tasks.

Medical staffing

- There were systems in place to ensure medical staffing levels provided safe care and treatment at all times. The hospital had 98 consultants and 11 consultant

radiologists working under the rules of practising privileges. The radiologists all belonged to the 'Salisbury Radiology Group' and all worked as consultant radiologists in a nearby NHS hospital. The hospital had a corporate policy manual called 'Facility Rules' which assisted in the selection and granting of admitting and/or practising privileges.

- Practising privileges were granted to consultants who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration. Most of the consultants worked in the NHS and so received their appraisal and revalidation with the trust they worked for. Revalidation information was shared with New Hall Hospital when required. We saw staff records that confirmed appraisals and revalidation were up to date.
- There was resident medical officer (RMO) cover 24 hours a day provided by an external organisation. The RMO worked two weeks on duty followed by two weeks off; however, there was always back from an on-call RMO doctor if required when the RMO had been particularly busy. RMOs undertook all mandatory training, including advanced life support training for children and adults, appraisal and revalidation via their employing organisation. This was governed by a service level agreement with the Ramsay Groups and meant that the RMO did not have to attend and comply with local training requirements.

Major incident awareness and training

- The hospital had arrangements in place to respond to emergencies and major incidents. We saw policy folders with a business continuity plan and action cards to guide staff in the event of a major incident or unforeseen circumstances such as adverse weather conditions. Staff were aware of where the folders with the information were kept. We checked that it was an up-to-date action plan and a named manager duty rota demonstrated compliance for the following weekend.
- There were protocols in place to help staff deal with incidents during use of the scanners and scenario based training took place regularly. Staff told us how they had dealt with a recent episode where the lift to the scanner had broken down; the radiology department cancelled all scans that day as there was no facility to evacuate patients safely in a medical emergency. All appoints were re-scheduled and apologies offered to patients who were affected by the incident.

Are outpatients and diagnostic imaging services effective?

The effectiveness of outpatients and diagnostic imagining was not rated due to insufficient data being available to rate these departments' effectiveness nationally. On inspection we found:

- The service delivered care and treatment based on national guidance.
- Multidisciplinary teams worked together in the 'one stop' urodynamic clinic (a study to assess how the bladder and urethra are performing their job of storing and releasing urine).
- The physiotherapy department covered inpatient care seven days a week.
- There was an effective on call rota for imaging staff that ensured emergency X-rays could take place out of hours and processes in place to transfer patients who needed emergency scans when the mobile scanner was not at the hospital.
- Information security audits confirmed records were stored securely.
- Staff obtained consent before treatment interventions however this was not always documented.
- Staff were generally up-to-date with appraisal and mandatory training. We saw comprehensive training folders confirming staff competencies.
- The imaging department had corporate standard operational standards for all procedures but they did not have local protocols although there was a plan to produce these in line with the recommendations set out in the National Safety Standards for Invasive Procedures introduced in 2015.
- The service did not collect patient outcome data or evaluate the effectiveness of care and treatment delivered.

- Consultants did not consistently issue a discharge letter to patients. This meant that in an emergency other healthcare professionals would not have access to information about a patient's recent health.

Evidence-based care and treatment

- Care and treatment was in line with legislation, standards and evidence-based guidance. For example staff in radiology followed the National Institute for Health and Care Excellence (NICE) guidance to minimise the risk of contrast induced acute kidney failure for patients having CT scans by ensuring blood test results were available before the scan and by advising patients to drink plenty of fluid following the scan.
- In the imaging department there were corporate standing operating procedures for clinical radiology, which were stored in the department and available for all staff. However, there were no local protocols but there was a plan to implement local safety standards for invasive procedures in line with national recommendations.
- Staff in the imaging department used local diagnostic reference levels and audited these as an aid to optimisation in medical exposure of radiation. Optimisation refers to the lowest dosage of ionising radiation given to achieve the best diagnostic images.

Nutrition and Hydration

- Patient's nutrition and hydration needs were met in the departments. We saw vending machines in waiting rooms where patients and their relatives could obtain chocolate and other snacks. There was free access to hot and cold drinks dispensed into paper cups. We saw housekeeping staff clean the drinks stations regularly.
- In a patient-led assessment of the care environment (PLACE), the hospital scored 97% for food and hydration, which was well above the national average of 88%.

Pain relief

- Staff in the outpatient department, radiology and physiotherapy department told us they were rarely required to administer pain relief to patients but consultants offered and gave local anaesthesia for minor procedures. We observed a nurse and registered medical officer speak with a patient about their pain and gave advice about how often they could take painkillers and of the dosage, they should take. When they spoke with the patient, they used a recognised tool (pain scale) to help the patient describe the severity of their pain.
- In the imaging department, consultant radiologists provided ultra-sound-guided injections to provide pain relief for patients with certain medical conditions.
- In the physiotherapy department, we observed an appointment with a patient following shoulder surgery. The physiotherapist assessed the level of pain and advised the patient about what they could do to help minimise the pain, related to wearing a sling for the arm, which caused some discomfort to the neck. The physiotherapist spoke with the patient about exercising within pain limits, not to advance too fast or exercise beyond their pain barrier.

Patient outcomes

- The hospital did not yet participate in the imaging services accreditation scheme (ISAS) which is currently a voluntary scheme and therefore participation is not a requirement. Senior managers told us that Ramsay Health Care UK had a long term aim to undertake ISAS accreditation of some sites of which New Hall would look to become one of the first sites to undertake the accreditation.
- Senior management told us that Ramsay worked 'to the spirit of ISO 9001'as their set of quality standards for the diagnostic imaging department and that, the hospital had engaged with ISAS with a view to progress towards accreditation in the future. ISO 9001 Certification are standards that ensure organisations have quality systems that will provide the foundation to better customer satisfaction, staff motivation and continual improvement.

Competent staff

- At the time of our inspection, all doctors including radiologists working under practising privileges in the hospital had registration with a professional body, indemnity insurance and an up-to-date disclosure and barring service check. Patients could search the hospital's website to find out more information about consultants.
- Each consultant had an annual review with the general manger for the hospital. At this review the consultant's

records were checked to ensure they had received and appraisal and revalidation was up to date, usually via the hospital where they held their substantive post. Their activity at New Hall Hospital and thoughts on the service provided were also discussed.

- The hospital had a corporate induction policy for new employees, those transferring between units, promoted or returning to work after an extended period of absence. The policy also included an amended induction process for contract staff, regular bank staff, agency and locums. We spoke with a member of staff who had been working at the hospital for five weeks. They felt well supported and had a 'buddy'; managers ensured shadowing opportunities and had regular meetings to discuss progress. In the imaging department, the induction process also covered use of equipment and the associated local rules.
- Staff had an annual appraisal and these were well documented in individual training folders. Staff were encouraged and offered opportunities to develop and this support extended to all staff. We were told about a health care assistant who was funded to complete an apprenticeship in health and social care through a scholarship and we met with another member of staff who had been supported to develop their career within the hospital and supported in their career development by obtaining promotion opportunity in another Ramsey hospital.
- All registered staff in the outpatient department were trained to respond to medical emergencies. Registered staff in the outpatient department had intermediate life support training and healthcare assistants had basic life support training. There was a registered medical officer trained in advanced life support for both children and adults on duty 24 hours a day.
- All staff in the imaging department were registered radiographers and only radiographers operated the image intensifier in the theatre department.
- There were systems in place to ensure that consultants working under practising privileges only carried out treatment and procedures they were skilled and competent to perform. All consultants and consultant radiologists also worked in NHS hospitals carrying out similar treatment and procedures. If a consultant retired from their NHS work they had to carry out enough of a particular procedure each year in order to continue to practice. The number of procedures that needed to be carried out annually to maintain competence were laid down by the various royal colleges and the consultant and general manager of the hospital had to be mindful of this.
- Consultants had an annual meeting with the general manager to ensure adequate appraisal, training and revalidation was up-to-date to continue working under the rules of practising privileges. The hospital took action if consultants did not comply with all requirements and had removed a consultant's practicing privileges in the last 12 months for failing to keep equipment adequately serviced and maintained. The service had recently introduced a system that linked consultants pay review to completion of mandatory training to increase the compliance levels.

Multidisciplinary working (related to this core service)

- Staff, teams and services worked together to deliver effective care and treatment. The radiology department ran a one-stop urodynamic clinic for patients with haematuria (blood in the urine). This meant that patients would have a consultation, have urodynamic studies and have a result or diagnosis with further treatment planned, all in one day.
- There was a service level agreement in place with a local hospital to ensure staff referred and transferred patients who needed an emergency scan. Radiologists working at the local NHS trust would report on the scans to ensure timely treatment for patients.
- The hospital had increased the number of spinal operations they carried out, which meant there was increased work for radiographers to operate the image intensifiers in the operating department.
- The hospital worked with a nearby NHS trust to offer spinal patients the opportunity to use a hydro pool to extend their physiotherapy following surgery.
- The mangers for each department had extended access to working with peers in the Ramsay Health Care group such as attending regional meetings and being signed up for 'group emails' to share practice across Ramsay hospitals.

Seven-day services

Good

Outpatients and diagnostic imaging

- The outpatient department was open six days a week to help accommodate patient's choice of appointment as far as possible.
- The radiology department was open five days a week and had an on call rota to cover emergencies at weekends. The hospital had a service level agreement with a local NHS trust to access radiologist cover out of hours, which meant that X-ray images were reported on in an emergency.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. We spoke with medical secretaries who were responsible for ensuring patients medical records were available for clinics in the outpatient department. All medical records stayed onsite to ensure access and availability.
- On discharge from the hospital, the secretaries sent a discharge letter to all patients' GP with information about care and treatment the patient had received at the hospital. We learnt that not all consultants provided a discharge letter to the patient. This meant there was no written account of the treatment episode to share with other healthcare professionals in case of an emergency.
- Departments held regular meetings for staff and there were efficient systems in place to update staff that could not attend each meeting. Minutes, policies and other information were stored in folder for staff to read and sign. There were noticeboards in non-clinical spaces such as department offices for staff to read information.
- There was a daily 'huddle' for all heads of department, where operational issues would be discussed such as number of clinics. Relevant information was shared with staff in each department, following the 'huddle', by the head of the department.
- Staff told us of 'EIDO' boxes where written information about how to obtain written information in different languages, specifically with respect of obtaining informed consent, could be accessed. These information leaflets would be printed off in advance of an appointment if it was clear that it may be needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The departments encouraged and supported patients to make decisions about their care and treatment. Staff involved patients in decisions and obtained verbal consent prior to care or treatment interventions. For minor procedures, staff obtained informed consent in writing. There were leaflets available in the outpatient department about consent, which included advice about what do if they were not happy about the way they were approach about consent.
- The hospital had policies about consent, mental capacity and the deprivation of liberty. Staff were aware of how to access the policies but told us it was not something they came across at the hospital very often. Staff received training as part of mandatory training programme and mangers told us that each department was compliant. The hospital provided training compliance data from June 2016, which showed the radiology department was 100% compliant; the outpatient department was 91% compliant while the physiotherapy department were 72% compliant. Managers told us that staff had worked hard to complete mandatory training in preparation for the inspection.

Are outpatients and diagnostic imaging services caring?

Good

By caring, we mean that staff involve and treat people with compassion, dignity and respect.

We rated caring of the outpatient and diagnostic services as good because:

- We observed caring and kind interactions between staff and patients.
- The service had good provision of chaperone services.
- Patients told us they were always treated with dignity and respect.
- Patients told us that confidentiality was always maintained.
- Patients were involved with arranging appointments to suit their needs and circumstances.

- Staff discussed questions about fees openly with patients.
- The service gave patients extensive information about their care and treatment so patients could make an informed decision about their care.

Compassionate care

- Staff took time to interact with people. We observed interaction between patients and different staff groups in all clinical areas of the outpatient and imaging departments. Staff cared for and responded to patient's needs in a kind manner.
- The service treated patients and their relatives with kindness, dignity, respect and compassion. We observed receptionists, nurses, doctors and radiographers greeting people politely and introducing themselves to the patient. The reception staff were mindful of speaking with patients in a manner that ensured confidentiality, even though the reception area in the outpatient department was quite open. Staff called in patients by name in the outpatient department and the imaging department. For patients attending the physiotherapy department, the physiotherapist collected the patient from the waiting lounge near the main hospital reception desk.
- The outpatient department offered patients a chaperone for all consultations and staff ensured the presence of a chaperone for examinations of an intimate nature. If a chaperone could not attend, or if the patient asked for a chaperone of the same sex and this could not be facilitated, the hospital offered the patient another appointment. There were posters displayed in the outpatient department about the chaperone service and it was included in patient leaflets the hospital sent out prior to their appointments. The outpatient department had stamps to indicate if a patient had or had not declined a chaperone during the consultation. The compliance was not monitored even though this was suggested in the corporate chaperone policy
- In a patient-led assessment of the care environment (PLACE), the hospital scored 80% in maintaining privacy, dignity and well-being, which was below the national average of 87% and 79% for dementia care, which was also below national average of 81%. The hospital had a dementia strategy and improving dementia care was one of the hospital's clinical priorities. The hospital screened all patients over the age of 75 for memory problems and dementia at pre-admission.
- There were three cubicles with curtains to allow patients to change for scans in the imaging department. They were curtained off and allowed dignity for patients to be maintained.
- In the physiotherapy department, a designated physiotherapist treated women with women's health problems. However, staff could not rule out accidental entry to the treatment room and there was no curtain to screen off, if the patient was required to undress for the treatment.
- There were signs on doors to indicate consultation and treatment rooms were in use and we observed staff knock and await answer before entering rooms.
- Patients told us staff treated them with care and respect, and kindness. Patients told us staff were efficient, polite and very helpful.

Understanding and involvement of patients and those close to them

- The hospital had a 'carer's charter' which encouraged patients to identify a close relative to work with both the patient and the hospital as partner's in care and in recognition of the important role carers play in supporting recovery and in maintaining health and well-being. The hospital respected patient confidentiality and would only share personal information with permission.
- Staff communicated with patients and those close to them to ensure they understood their care, treatment and condition. We observed a consultant in a follow up clinic where they answered questions in an honest but compassionate manner. We observed a nurse-led wound dressing clinic where the patient and their relative's received kind and compassionate care, questions were answered and explanations given. We observed a treatment session in physiotherapy department where a physiotherapist treated a patient with respect and dignity and gave the patient opportunity to ask questions; the physiotherapist allowed time to ensure the patient fully understood the instructions.

Good

Outpatients and diagnostic imaging

- Staff took care to communicate with patients in a polite manner but also used appropriate humour to create a relaxed atmosphere.
- We observed a physiotherapist give clear verbal explanations and demonstrations of their exercise programmes and followed up with written instructions that they gave to the patient. The physiotherapists checked the patients understanding several times during the consultation.
- The medical secretaries and booking administrator told us there was a private patient account manager who patients could access for advice including advice about costs.
- We spoke with eight patients and relatives who were happy with the treatment and care they had received in the outpatient department, in the imaging department and in the physiotherapy department. Comments included feeling safe, timely diagnosis and treatment, kind and respectful staff.
- While we inspected the hospital, we also offered patients, carers and others to leave feedback in designated 'post boxes' around the hospital. Comments included "friendly and efficient staff", excellent care. Well run, feel safe, good timely diagnosis, care and treatment".
- Results of the 'NHS Friends and Family test' exceeded national average scores however; this was for inpatients and represented a response rate of 28-32%. We observed staff encouraging patients to complete feedback forms and were told that in fact some patients thought there was too much prompting from staff – in particular if patients were attending more than one episode of care and /or treatment. The hospital reported on the results of NHS Friend and Family test. Patients seen in the outpatient department (both NHS and private) scored above 98% in April 2016, which is higher than the NHS national average of 95%. For both NHS and private patients the response rate was to 7% and 12% respectively of patients attending appointments.

Emotional support

- Staff understood the impact a person's care, treatment or condition could have on their wellbeing and on those close to them. We observed staff in the outpatient department discuss and facilitate an appointment for a patient who had rung the department with concerns following their discharge. Staff worked together to arrange for the patient to come in the same day to see the consultant.
- We observed two staff from the imaging department escort a patient to the mobile scanner unit. The patient explained they were nervous and staff took time to reassure the patient before the scan.
- Staff communicated with patients in a relaxed and reassuring manner and sometimes used appropriate humour to help alleviate patients' anxiety.

Are outpatients and diagnostic imaging services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated the outpatient and diagnostic services as good because:

- Reception staff helped patients as required and the waiting areas were bright and comfortable.
- Patients had a choice of appointments to suit their needs.
- Patients did not wait long on the day of their appointment.
- Referral to treatment time exceeded targets and meant that 100% of patients were seen within 18 weeks from referral.
- The hospital had a complaint policy and handled complaints in a timely manner. There was evidence the service made changes because of lessons learnt from complaints.
- There was a robust process to triangulate all patient feedback in order that learning took place and changes were made in response to feedback.

However,

- The building and car parking facilities posed some challenges to ensure compliance with people's needs.

- The hospital did not consistently assess patient's communication needs and did not comply with Access to Information Standards.

Service planning and delivery to meet the needs of local people

- The service worked hard to ensure the hospital provided services that met the needs of the local and wider South West population. We spoke with the three Clinical Commissioning Groups (CCG) who worked with the service. They all reported good working relationships with New Hall Hospital. They said the service was proactive in identifying ways to be more effective and efficient and demonstrated continual improvement and were patient focussed.
- The environment was not always appropriate and person-centred. If patients were not familiar with the layout of the hospital, it was not easy to find their way around. There was limited signage for example for patients attending the imaging department as part of their outpatient appointment and signage to the physiotherapy department was not easy to follow. The signs were also not easy for people with impaired vision to see and read. However, lifts were spacious to accommodate wheelchair users and there were toilet facilities suitable for disabled people. These facilities also had a call bell to call for help although this was not the case for all patient or public toilets. The toilet facilities were visibly clean and there were records displayed to show the toilet facilities were cleaned three times a
- The main reception area was bright and welcoming and had alcohol gel for patients and visitors to gel their hands before entering clinical areas. The main waiting area was spacious, bright and welcoming with a choice of seating for people to choose what would be most comfortable. There were nice views and a choice of daily papers or magazines to read. Reception staff were professional and greeted patients with a smile. They offered help immediately and directed patients to the appropriate area or on occasions escorted the patient.
- There was plenty of free parking for patients attending the outpatient department received written information prior to their appointment of which car park to use. The outpatient department was on two levels with no interconnecting lift. This meant in order for a patient to have easy access and to avoid stairs the hospital advised patients to park in the designated car park for the appointment they were attending. However, the car park for the main upper level of the outpatient department was quite a distance away from the entrance and required patients to walk past other working departments at the back of the hospital. There were three allocated disabled car parking bays close to the entrance but manoeuvring into these spaces could be difficult and interfered with the main access path to the entrance.
- The hospital used a Ramsay Diagnostics Group mobile scanner unit to facilitate CT and MRI scans for patients. The MRI scanner visited the hospital twice weekly, this meant that patients did not have to wait long for their MRI scan although there was a waiting list for patients who needed a CT scan as the scanner was only onsite once a month.
- Radiologists working at the hospital reported on the MRI and CT scans and the turnaround time for reporting was 24 to 48 hours. The hospital had a service level agreement with a local NHS trust for patients who needed an emergency scan at any other time, which meant the patients were referred to and transported to the local NHS trust by ambulance .
- The physiotherapy department had a service level agreement to access the use of a hydro pool at a nearby NHS hospital. This facility was used particularly for patients who had had spinal surgery.

Access and flow

- The hospital accepted both private and NHS patients using the 'choose and book' facility once referred by the GP. The hospital had a target for seeing new patients within 18 weeks from referral to treatment (RTT). The hospital's RTT waiting times were 99-100% for the period from April 2015 to March 2016, which meant the outpatient department saw all patients within 18 weeks, which is well above NHS England target of 92%.
- The imaging department saw all patients within six weeks of referral for CT, MRI and non-obstetric ultrasound, in the period from April 2015 to March 2016. Staff managed all the bookings including managing access for patient referred for an X-ray by their GP, which the department would carry out on the same day.

Good

Outpatients and diagnostic imaging

- We spoke with patients and their relatives in the waiting areas in the different departments. They all said they had received good treatment but one relative said that they sometimes had to wait for a long time on the day of the appointment however, staff kept them informed of any delays. There was no display of anticipated waiting times; the hospital had considered the option of introducing a pager system so that patients could leave the department and walk around the grounds while they were waiting.
- The service monitored the rate of patients that did not attend for their appointments. There was a clear policy and flow chart for staff to follow and each missed appointment was followed up to ensure the patient's safety and review the reason for not attending. For example the service may not have the right address for patients when new appointments were made. These reasons were reviewed for trends and used to evaluate how responsive the hospital was to the patients who were treated at the hospital. If patients repeatedly did not attend and if the hospital was unable to get in touch with them, a letter was sent to the patient's GP for them to follow up.

Meeting people's individual needs

- The service did not consistently comply with the accessible information standards. The Equality Act 2010 places a legal duty on all service providers to take steps or 'make reasonable adjustments' in order to avoid putting a disabled person at a substantial disadvantage when compared to a person who is not disabled. The Accessible Information Standards (2015) directs and defines a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where these relate to a disability, impairment or sensory loss. The standard applies to (but not only) to people who are blind or is partially sighted, deaf or have a hearing disability, people with learning disabilities, autism or mental health condition which affects the ability to communicate. Full implementation was required by July 31st 2016.
- While the service had information leaflets available in Braille, large typescript and various languages, there was not a consistent approach to assessment of patients communication needs although the electronic appointment system had a facility to highlight individuals needs and risks.
- In the imaging department, we observed how staff interacted with a patient who used a wheelchair. Staff offered assistance to sit comfortably in the waiting room whilst making an appointment for a MRI scan. The hospital offered patients a choice of date and time to suit their needs and the patient completed a safety questionnaire in preparation of the scan.
- There were three cubicles with curtains to allow patients to change for scans in the imaging department. They were curtained off and allowed dignity for patients to be maintained.
- In the physiotherapy department, a designated physiotherapist treated women with women's health problems. However, staff could not rule out accidental entry to the treatment room and there was no curtain to screen off, if the patient was required to undress for the treatment.
- The service took account of people's individual physical needs. For example in the physiotherapy department there was a treatment couch suitable for bariatric patients, there was signposted toilet facilities suitable for people in wheelchairs and lifts to enable patients with poor mobility to access different levels of the hospital.
- The service recognised the importance of flexibility and choice for patients and sought to provide access by facilitating early evening and Saturday appointments as far as possible.

Learning from complaints and concerns

- The hospital had systems in place for handling complaints effectively. The policy was available to staff and they were knowledgeable about how to handle complaints at point of care and how to support patients to make a formal complaint.
- The hospital handled complaints effectively and in a timely manner. The general manager shared all complaints in heads of department meetings, senior management meetings and the customer quality group that fed into the clinical governance committee. Minutes of meetings confirmed complaints formed part of the

set agenda for these meetings. In addition to this, the quality improvement manager triangulated all patient and carer feedback, including complaints and feedback, which had been referred to the hospitals patient advice and liaison service or the ombudsman. The quality improvement manager triangulated all feedback to ensure learning and change could occur. They produced quarterly reports and shared this with the clinical governance group and senior managers.

- The hospital was part of the independent healthcare sector complaints adjudication service and there had been no referrals made in the period from April 2015 to March 2016.
- The hospital had a customer quality group, which discussed feedback including complaints, from patients so that lessons could be shared and practices changed if required. The group shared feedback with the wider hospital staff via a poster called: you said, we heard and we did. Managers displayed these posters on notice boards in their department and listed examples of how changes to practice were made.
- We asked for examples of changed practices following complaints and staff in the imaging department told of a complaint they received in April 2016 where a patient's x-ray report was not with the patient's GP a week after the scan. The department now sends out reports to GPs by first class mail instead of using internal mail system.

Are outpatients and diagnostic imaging services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, support learning and innovation, and promotes an open and fair culture.

We rated well-led of the outpatient and diagnostic services are good because:

- The hospital had a clear corporate vision and strategy that staff were knowledgeable about.
- There was a robust clinical governance framework and evidence of shared learning from incidents.
- There were local risk registers and evidence of actions to mitigate/reduce risks.
- There were effective systems in place to ensure learning from incidents and complaints was shared with staff to improve practice.
- There were systems in place to review and grant practicing privileges for consultants working at the hospital.
- There was a culture of empowering staff to engage with the development of departmental clinical vision and identified actions to achieve this.

However,

- There was evidence that the hospital took local responsibility for compliance with workforce race equality standards at a corporate level but not at individual hospital level.
- The hospital scored below 80% in five measures, out of 12 measures, in a recent staff survey and it was not clear how the hospital planned to address this.
- The imaging department had not yet engaged with the development of local safety standards for invasive procedures in line with recommendations, although there were plans to do this in the near future.

Vision and strategy for this this core service

- The hospital had a clear corporate vision and strategy. Both management and staff referred to this as the 'Ramsay Way'. In addition to the corporate vision and strategy, each department had set out their own vision and strategy and these had been compiled to form the clinical strategy for the hospital. This meant that not only were staff engaged but also empowered to influence and improve practices and procedures. Almost all the staff we spoke were clear about their role and contribution although a few seemed disengaged. The strategy set out goals, actions of how to achieve the goals and measures by which to measure their success. Managers told us the involvement of staff had boosted morale and motivation.
- Each department had set out their own vision and these included provision of outpatient services that always were safe, effective, caring and responsive, innovative and well-led. In the imaging department the staff vision was to create a service patients wanted to return to

while staff in the physiotherapy had agreed that the vision for their service was to deliver and maintain a high quality service to their customers and to attain a high satisfaction rate from both patients and staff.

- The hospital had a patient charter that included their values, they called it 'our commitment to you, the Ramsey way'. The patient charter set out strategies to deliver care in privacy, with compassion, dignity and respect. Staff were aware of the ethos of the 'Ramsey Way' and posters were displayed for patients to read,
- Clinical staff we spoke with referred to the '6C's' in the delivery of care. The 6C comprises of care, compassion, communication, competence, courage and commitment. There were posters displayed to encourage and remind staff.

Governance, risk management and quality measurement for this core service

- There was a robust governance framework to support the delivery of good quality care. We found there was a clinical governance structure, comprehensive strategies to obtain patient feedback, encouragement from senior management team to engage staff in developing visions and strategies and a competent workforce.
- We saw risk registers, and managers were knowledgeable about most risks in their department and took responsibility for mitigating actions to ensure safe practice.
- The hospital had a comprehensive governance framework that ensured clear lines of responsibilities and that quality, performance and risks were understood and managed. Managers and senior managers discussed incidents, risks and complaints at heads of department meetings, in clinical governance meetings and at the medical advisory committee. Where actions were identified these were assigned to named people to ensure staff took responsibility to complete improvement actions demonstrating oversight of performance indicators and risks to performance. The framework ensured efficient communication from 'ward to board' and 'board to ward'.
- The outpatient department manager had a dual role of managing a department and managing the role of quality improvement manager. The quality improvement manager compiled comprehensive reports (clinical incidents, audit summary report and 'patient and carer feedback triangulation report') and shared these with the clinical governance committee, the medical advisory committee, and in head of department meetings. There were standardised meeting agendas to ensure consistency and that important areas affecting performance and quality, were discussed regularly.
- Organisational learning was shared with staff in a number of different ways for example 'bite size bulletins' and 'you said, we heard and we did' notices displayed in staff areas on so-called 'quality boards'. Clinical staff had access to a shared organisational learning folder on the hospital intranet.
- There was a comprehensive audit calendar at the hospital. We spoke with the quality improvement manager who collated all the audit information into a summary report and presented this to the clinical governance committee. We reviewed the summary report for quarter one 2016-17, which confirmed 100% compliance with audits (24 audits) although some reports were submitted late. The report clearly demonstrated how the audits results were reviewed and actioned.
- There was a plan in place to ensure implementation of local safety standards for invasive procedures in September 2016 in line with national recommendations. The hospital planned to implement the standards in both outpatients department and in radiology. These standards would help ensure the safety of patients undergoing invasive procedures.
- The hospital had 98 doctors/consultants working under the rules of practicing privileges. A corporate document outlined the policy for granting or admitting practicing privileges to health care professionals. The medical advisory team supported the general manager in making decisions about the granting of practising privileges for consultants.
- The hospital had processes in place to manage and monitor service level agreements with third parties. The processes involved an annual review of the agreement

with the third party. They could also be reviewed in between the annual review if any guidelines or legislation changed that affected any aspects of the agreement.

Leadership / culture of service

- Staff we spoke with felt valued and respected. There was good support for well-being and access to occupational health services for employees. Managers told us that there was recognition that staff were the most important assets of the service and recruitment concentrated on employing staff with the right core values.
- Many staff members had worked at the hospital for a number of years and they were happy in their jobs. One nurse described colleagues as family. Staff told us there were opportunities for development and support to complete courses. We asked staff about the presence of senior management and all staff we spoke with confirmed that senior management was very visible around the hospital, they were approachable and knew them by their first names.
- We spoke with the department managers and all stated that they were proud of the team they were working with. Managers stated that the team were committed to high standards of care and that the team was proud of the feedback they received from their patients. They stated they were proud of their working relationships with doctors and other departments in the hospital.
- We spoke with staff from the medical secretaries and bookings administrators, outpatient department, imaging and physiotherapy department who all told us they had good support from their manager. Staff also felt they worked well as a team and they were proud of that. We were told of friendly inter departmental competitions which brought teams closer together and one member of staff spoke of 'team New Hall' when referring to colleagues across the hospital.
- The head of department for the outpatient department had a dual role as manager for the department and quality improvement manager. We asked them how the dual role worked. They told us they had confidence in the team and the way the department was running. They had good support from the staff and a deputy manager who was competent to run the department in their absence. The deputy manager was about to retire but an equally competent senior nurse with experience and knowledge of the department, had been successfully appointed to take over as deputy department manager.
- The hospital sought to promote the well-being of staff. The hospital's customer quality team recognised individual staff or department success by celebrating 'idea of the month' and 'employee/ department of the month'. However, there was not a proactive approach to risk assessments for office personal concerning workstation assessment.
- The hospital had a disclosure of information policy (otherwise known as whistle-blower policy) which stated staff could disclose Information without fear of detriment or victimisation. The policy gave assurances that staff confidentiality would be maintained but did not outline the support systems in place for staff who disclosed information.
- The hospital also had a policy for 'raising and reporting staff concerns' which encouraged all staff to express their concerns freely on all activities but it emphasized concerns about the delivery of care to patients.
- The hospital was open and honest about fees for private patients. The hospital's website held information for patients about services, consultant profiles, fees and payment options.

Equality and Diversity

- 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 £200, 000 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.
- There was a corporate 'Equality Duty and Actions Report 2016' giving information about equality in Ramsay's UK's workforce however, there was no report and action plans for the hospital. WRES (2015) encourage independent hospitals at local level to monitor WRES data and produce local action plans to ensure compliance.
- We discussed WRES with the hospital general manager. The hospital had a Corporate Equality Duty Report (2016) which reported on WRES for the whole of Ramsay

Health Care UK. NHS England confirm that 'provider' in the independent sector refers to a hospital location and that reporting WRES only at corporate level would mask any variation in WRES performance in the different locations across the country. During our inspection, we met with two BME staff who felt well supported by the hospital.

Public and staff engagement

- The hospital engaged staff in the development of a clinical strategy and asked each department to identify a team vision and a set of goals to achieve their vision with actions, timeframe and measures to measure their success. Staff in the departments were pleased that they had the opportunity to formulate their own vision and goals for their respective departments. Staff told us that participating in the development of clinical strategy had boosted morale.
- The hospital obtained feedback from patients and carers using a range of methods including: Patient and carer feedback, NHS Friends and Family test, Ramsay online, external website and carer's survey.
- The hospital had a customer quality team who met quarterly to discuss patient feedback and staff engagement. Meeting minutes demonstrated that the team discussed feedback from patients and possible actions in response to negative comments. For examples the customer quality team discussed the option for relatives/carer's to purchase food in the hospital canteen.
- The hospital held regular educational seminars for all local GP's offering GPs an opportunity to meet consultants and ask questions. The hospital advertised these events on their website and included topics such as hand and wrist pain, common foot problems and sinus issues.
- The hospital offered a series of open events for the public. Members of the public were able to book a complimentary mini one-to-one assessment with a consultant as well as receiving cost guidelines. These events include varicose vein treatment and cosmetic surgery.
- The hospital conducted a survey for staff (My voice survey 2016). Staff engagement was 84%, which was higher in comparison with other hospitals. The scores for all 12 measures were consistently higher when compared to the other hospitals but scored below 80% in five measures (pay, benefits and recognition = 61%; health and well-being = 79%, my direct line manager= 79%; The senior management team = 75% and corporate leadership team = 38%). Although staff we spoke with praised their line manager and spoke well of the senior management team.
- The hospital took part in a Patient-led Assessment of the Care Environment (PLACE) in March 2015. The aim of the audit was to provide a snapshot of how the organisation performed against a range of non-clinical activities and which offered comparable data. The PLACE audit looked at five different measures and the hospital scored the same or above national average in two measures and below national average in three of five measures. The three low scoring measures were privacy, dignity and respect, the condition, appearance and maintenance of the building and dementia awareness. The hospital had recently undergone extensive renovation of the stable block to house the outpatient department. The hospital had a dementia strategy and dementia training was included in the mandatory training for staff.

Innovation, improvement and sustainability

- The hospital was awaiting the introduction of electronic care records in the near future. Managers acknowledged that this would solve some of the issues around separate consultants' notes for private patients and ensure all records were available and easy to read. The bookings manager had been involved with the planning stages and had identified 'super users' to help implement and trouble shoot once the system was introduced.
- The hospital had plans to move the physiotherapy department to create more space. Staff told us there were plans to introduce group sessions for patients as part of rehabilitation after surgery.
- The hospital had plans to purchase a MRI scanner and reconfigure the imaging department to accommodate a MRI suite for the safe scanning of patients.

Outstanding practice and areas for improvement

Outstanding practice

OUTSTANDING PRACTICE:

- Staff learning needs were identified and they were encouraged and given opportunities to develop. All staff we spoke with said they were supported and funded to undertake extra training and were given time to complete this. For example, one member of staff said they had requested to attend a training course which would be beneficial to their role. Another member of staff told us they had been approached by their manager and given the opportunity to attend the same course as they were employed in a similar role.
- There was strong evidence of a good culture amongst staff, and shared vision and objectives to improve patient care.
- There was strong focus on improving quality of care and people's experiences by monitoring feedback, complaints and reported incidents..

Areas for improvement

Action the provider MUST take to improve

- Ensure all departments have appropriate sinks, hot running water and soap to comply with infection control measures and that when audits suggest non-compliance, that this is actioned promptly.

Action the provider SHOULD take to improve

- Continue to consider the benefit of an on-call pharmacy service.
- Ensure there is a system in place to check the temperature of the room used to store back up medicines so staff were able to assure themselves these medicines were always kept at a safe temperature.
- Ensure patients' medical history and reason for admission, especially when being transferred from another hospital, are clear in the patient care record and the blood test results pages are always completed.
- The hospital should continue to review processes for consultants are compliant with mandatory training requirements.
- Ensure the system put in place to improve compliance with safeguarding training is monitored and improvements are being made.
- Review patient information to make it clear to patients that different visiting hours relate to the accommodation, that is, single rooms compared to shared bays, and not the status of the patient.
- Ensure information relating to workforce race equality standards can be produced at a local level as well as at a corporate level, to ensure that the service complies with reporting requirements as outlined by NHS England.
- The services should review their process for monitoring daily cleaning of equipment and surfaces in clinical areas including auditing compliance.
- The hospital should review processes to obtain assurance that maintenance and water quality standards meet requirements to ensure safety for patients using the hydro pool at a nearby NHS hospital.
- The hospital should consider risk assessments for carpeted areas to ensure these are not used for any clinical procedures.
- The hospital should ensure that infection control and prevention measures are followed by all staff.
- The hospital should review their uniform policy to ensure compliance with national recommendations regarding effective washing of all parts of the uniform.

Outstanding practice and areas for improvement

- The services should monitor and log the use of prescriptions in the outpatient department to ensure there is an audit trail and that medication charts are completed accurately including information about allergies and stop dates for prescribed medicines.
- The hospital should ensure the use of the World Health Organisation (WHO) Five Steps to Safer Surgery surgical checklist for patients having minor surgery is audited for compliance and actions are taken if required.
- The outpatient department should audit compliance with chaperone attendance in line with their policy.
- The hospital should review and agree processes to ensure all patients receive a discharge letter in case of the need to seek assistance in a medical emergency.
- The hospital should adopt methods to collect and assess patients communication needs to comply with the Accessible Information Standards (2015).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15: Premises and equipment 15 (1) All premises and equipment used by the service provider must be – (a) clean (b) secure (c) suitable for the purposes for which they are being used (d) properly used (e) properly maintained, and (f) appropriately located for the purpose for which they are being used. (2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. Not all departments had appropriate sinks, hot running water and soap to comply with infection control measures. When audits suggest non-compliance, this had not been actioned promptly

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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