Woodland Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced, comprehensive inspection visit of Woodlands Hospital on 8 and 9 March 2016 and an unannounced inspection on 17 March 2016.

Our key findings were as follows:

We inspected two core services, surgery and outpatients and diagnostic imaging. Overall the hospital requires improvement for safety and well led in surgery and well led in outpatients. However, caring and responsive was rated good in both core services we inspected. Effective was judged to be good in surgery, but was not rated in outpatients, because the Care Quality Commission's view is that we are unable, at present, to collect enough evidence to rate this key question.

Are services safe at this hospital/service

Systems, processes and standard operating procedures were not always reliable or followed to protect patients from avoidable harm. For example, infection prevention and control measures did not ensure patient safety. Operating theatre staff did not use the correct theatre attire, including gowns and footwear, when leaving and returning to theatre from other areas of the hospital, or always clean their hands when entering and leaving the department. The 'five steps to safer surgery' were used. However the principle behind taking time out before commencing surgery was not fully practiced with all staff present and participating.

A National Early Warning Score (NEWS) was used to identify deteriorating patients and there was a service level agreement for the transfer of an acutely ill patient to the local NHS hospital, should the need for this arise.

When something went wrong, there was an appropriate investigation that involved relevant staff and lessons learned were communicated promptly to support improvement. In addition, staff understood their responsibilities in ensuring Duty of Candour ensuring patients were kept informed of near miss and actual incidents that involved them.

Staffing levels and skill mix were planned, implemented and reviewed.

There were systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. These were understood by staff.

Plans were in place to respond to emergency situations, although information for staff was not up to date.

Are services effective at this hospital/service?

Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. There was participation in relevant local and national audits, including clinical audits and other monitoring such as benchmarking and service accreditation in surgery and diagnostic imaging. However, in outpatients, audits were not undertaken.

Patient's needs were assessed taking account of their physical, clinical and mental health, although there was limited knowledge of Mental Capacity Act (2005) in outpatients.

Staff were qualified and had the skills they needed to carry out their role effectively, this included appraisal and reflective practice. However, most were not trained to the correct level of safeguarding.

Staff could access the information they needed to assess, plan and deliver care to patients in a timely was and there were secure systems to manage care records.

Consent to care and treatment was obtained in line with legislation and guidance.

Are services caring at this hospital/service?

Summary of findings

Patients were supported, treated with dignity and respect, and were involved in planning their treatment and care. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.

Patients were communicated with and received information in a way that they could understand.

There were appropriate arrangements to support and meet patients' emotional needs.

Are services responsive at this hospital/service?

The needs of different patients were taken into account when planning and delivering services, for example, on the grounds of age, disability or gender. In addition care and treatment was coordinated with other services and other providers.

It was easy for patients to complain or raise a concern. Complaints and concerns were taken seriously, responded to in a timely way and listened to within most departments. However, in the outpatients department, complaints were not shared with the team in order to effect improvements.

Some improvements to the quality of service had been made in response to patient feedback and concerns.

Are services well led at this hospital/service?

There was a statement of the hospital's values, based on quality and safety. However we found that staff had limited awareness of this statement.

There were integrated governance arrangements to minimise risk and ensure shared learning, however these were not always acted upon.

The risk register was not updated regularly. In addition, generally, staff were unaware of the contents of the risk register so that this could be used effectively.

There was poor compliance with some infection prevention and control practices of which the senior management team were unaware.

There were areas of poor practice where the provider needs to make improvements.

Action the hospital MUST take to improve

- The hospital must ensure that risks are identified, recorded, reviewed regularly and timely action is taken to mitigate them.
- Systems should be in place to ensure emergency equipment and medicines are safe and fit for purpose.
- Staff who have responsibility for assessing, planning, intervening and evaluating children's care, must be trained to level three in safeguarding.

Action the hospital SHOULD take to improve

- The hospital should ensure that the work commenced following the inspection to ensure that theatre staff do not wear their theatre shoes outside the department and that their scrubs are covered, continues. This is in line with Association for Perioperative Practice guidelines.
- The hospital should continue the work commenced following the inspection, to ensure that the operating department is not used as a thoroughfare for members of staff.
- The hospital should ensure that all staff present within the operating theatre are recorded.
- The hospital should ensure that the principle behind taking time out before commencing surgery is fully practiced with all staff present and participating.

Summary of findings

- The hospital should develop a local protocol for the management of changes to operating lists as specified in the hospitals operational policy for operating theatres.
- Learning from complaints, audits and incidents should be reviewed and information about learning shared within a communication system with staff.
- Locally devised clinical audits should be considered to monitor service improvements.
- The hospital should monitor patient waiting times in response to patient feedback received, to try and improve patient experience.
- The hospital should ensure that hard copies of histology and cytology results are kept in a secure area, not consultants post trays, in order to protect patients' confidential information.
- The hospital should ensure that there is a system in place to keep emergency contacts details up to date.
- The hospital should ensure that there is an annual major incident scenario is undertaken, in line with Ramsay policy.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	We found that surgical services were good for effectiveness, responsiveness and caring, but required improvement for the services to be considered to be safe and well led. Compliance with infection prevention and control measures did not always ensure patient safety and managers were not always aware of poor practice. Processes to ensure patients' safety were not always followed in the operating theatre. Department managers did not check systems to ensure emergency equipment and medicines were safe and fit for purpose. There had been no major incident training and emergency contact details were out of date. Incidents were reported and dealt with appropriately and trends and actions to minimise risks were communicated to staff. Patient areas were visibly clean and tidy. Patients were assessed, treated and cared for in line with professional guidance. There were effective arrangements in place to monitor and manage pain. Patient surgical outcomes were monitored and reviewed through formal national and local audit. Nursing, medical and other healthcare professionals were caring. Patients were positive about their care and experiences and were treated with dignity and respect. The service reviewed and acted on feedback about the quality of care received.
Outpatients and diagnostic imaging	Good 	The overall rating for outpatients and diagnostic imaging services was rated as good for safety, responsiveness and caring. The well-led domain we rated as requiring improvement. Patients spoke very highly of staff, and the majority felt that they were welcomed, treated with dignity and respect, and kept informed of any appointment delays.

Summary of findings

The hospital had provided good disabled access and support for patients with motor and sensory disabilities.
The radiology department had up to date standard operating procedures and quality assurance audits to monitor patient and staff safety.
The outpatient's team had recently introduced a competency buddying system to aid peer colleagues with the review and sign off of competencies required for their nursing roles.
Staff we spoke with were unfamiliar with the contents of the risk register and we saw no evidence of this regularly being reviewed to monitor mitigating actions.
Audit data collection was taking place but these were corporately led audits and there was no locally driven outpatients audit. There was also no involvement in national clinical audits or reviews.
Corporate audits undertaken were not completing the audit cycle by analysing the data, putting actions in place with a responsible lead and timeframe, then re-auditing to monitor improvements.
Patient survey data demonstrated that some patients were dissatisfied with waiting times for clinics, but there had been no audit or data collection put into place to monitor and service improve this.
Individual members of staff had very specialist skills which were not being cross covered by colleagues in their absence; we saw evidence of this in both nursing with provision of mental health capacity assessments and within support service teams.

Summary of findings

Contents

Summary of this inspection

Page

Background to Woodland Hospital 9

Our inspection team 9

How we carried out this inspection 9

Information about Woodland Hospital 10

Detailed findings from this inspection

Overview of ratings 11

Outstanding practice 46

Areas for improvement 46

Action we have told the provider to take 47

Requires improvement

Woodland Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Woodland Hospital

Woodland Hospital is a private hospital in Kettering, Northamptonshire. It has 39 registered beds. The hospital was opened in 1990 and, is purpose built over three floors. During this period the hospital has seen a number of changes, including a major development, in 2013, increasing the overall footprint of the unit.

The registered manager has been in post for over four years.

The hospital provides outpatient consultations to both adults and children. The outpatient department comprises 12 consulting rooms together with two minor treatment rooms. The hospital offers imaging and physiotherapy services in addition to a pharmacy department providing services for both inpatients and outpatients. All outpatient services are situated on the ground floor of the building.

On the first floor, there are six day case patient rooms, seven in patient rooms and a six bed recovery bay. On the same floor, the operating suite includes three main theatres with laminar flow with a seven bay, first stage recovery area. The endoscopy unit, also on the first floor, has Joint Advisory Group (JAG) accreditation.

The inpatient services on the second floor, comprises 21 patient rooms and a two bedded unit where patients can be more closely observed.

The hospital undertakes a range of surgical procedures and treats adults. The hospital suspended its day case surgical service for children over three years of age on 1March 2016.

There are 114 consultants working under practising privileges; none were directly employed by the hospital. There were 43 health professionals, administrative and clerical and support staff who were shared across the hospital services and who were employed by the hospital.

The hospital is managed by Ramsay Healthcare UK Operations Ltd part of a network of over 30 hospitals and day surgery facilities and two neurological rehabilitation homes, across England. In addition they own and run hospitals in Australia, Indonesia and France.

The hospital provides care for private patients who are ether paid for by their insurance companies or are self-funding. Patients funded by the NHS, mostly through the NHS referral system can also be treated at Woodland Hospital.

Our inspection team

Our inspection team was led by:

Inspection Lead: Kim Handel, Inspection Manager, Care Quality Commission

The team of seven included CQC inspectors and a variety of specialists: theatre nurse, consultant surgeon and governance specialist.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 8 and 9 March 2016 and an unannounced inspection on 17 March 2016. We spoke with a range of staff in the hospital, including nurses, allied health professionals, support staff and consultants. During our inspection we reviewed services provided by Woodland Hospital in the ward, operating theatre, outpatients, pharmacy and imaging departments.

During our inspection we spoke with 15 patients and 47 staff, including consultants, who are not directly employed by the hospital. In addition, we spoke with six family members/carers from all areas of the hospital,

Summary of this inspection

including the wards, operating theatre and the outpatient department. We observed how people were being cared for and reviewed personal care or treatment records of patients.

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

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

Information about Woodland Hospital

The hospital has 39 beds, most with ensuite facilities. Seven of these are used for day patient care currently. There are three operating theatres, all with laminar flow, 12 consultation rooms and an endoscopy unit.

Woodland Hospital provides an inpatient and outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery and urology. There were 10,187 procedures carried out between October 2014 and September 2015. 2,411of these were patients who stayed one or more nights and the remainder, 7,776, were day cases.

Between October 2014 and September 2015, 40,268 people were seen in outpatients. The outpatient department provides a local anaesthetic minor operation service.

Between October 2014 and September 2015 around 65% of the patients having day or inpatient treatment were funded by the NHS, the remaining patients were self-funding, or paid for by their insurance companies. In outpatients 68% of patients were patients funded by the NHS, the rest by other means.

114 doctors have practising privileges and their individual activity is monitored. There are 90 whole time equivalent employed staff.

Woodland Hospital has Joint Advisory Group (JAG) accreditation and is accredited by all the major private medical insurers.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day by an onsite resident medical officer (RMO.) Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital.

The hospital Accountable Officer for Controlled Drugs (CDs) is the Matron.

The hospital has a contract with Kettering General Hospital NHS Trust Hospital, which is nearby, to provide haematology, biochemistry and microbiology services. Pathology, histology and services are provided by an independent laboratory. Decontamination in relation to theatre instrumentation is provided by another nearby Ramsay centre.

Woodland Hospital has been inspected three times by the Care Quality Commission, between March 2013 and February 2014 with seven of the core standards in place at the time, being assessed during these inspections. Two standards assessed; supporting workers and requirements relating to workers were found to be non-compliant. However, by February 2014, there was only one outstanding non-compliance which was around supporting workers.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Information about the service

Woodland Hospital is registered for 39 beds. The first floor has seven patient rooms used for daycase patients all with ensuite facilities. In addition, on this floor, there are seven day case bays with trolleys for patients who do not require a bed following treatment and three cubicles for patients having procedures under local anaesthetic.

The second floor has 19 single rooms for in patients with ensuite facilities plus a two bed unit for the care of planned admissions requiring close observation. There are three operating theatres with laminar flow and a seven bay recovery area. Within the theatre complex there is also an endoscopy unit. The majority of the hospital's work is adult elective surgery, predominantly ophthalmic and orthopaedic surgery. Cosmetic surgery is also provided. In the reporting period from October 2014 to September 2015 there were 9,286 visits to theatre.

Woodland hospital ceased operating on children on 1 March 2016.

Patients are admitted under the care of a named consultant, and medical care is supported over 24 hours by an onsite doctor, the resident medical officer (RMO). Patient care is provided by a team of trained nurses, and allied health professionals such as physiotherapists and pharmacists, all employed by the hospital.

We carried out announced and unannounced onsite inspections of Woodland Hospital. We visited the inpatient ward, pre admission clinic, and the operating theatre department. We talked with eight patients. We interviewed 28 staff including nursing staff, RMO, consultants, administrative staff and managers. We observed care and treatment and reviewed six clinical records. Prior to, and after the inspection visits we reviewed performance about the hospital.

Requires improvement

Surgery

Summary of findings

We found that surgical services were good for effectiveness, responsiveness and caring, but required improvement for the services to be considered to be safe and well led, because:

- Compliance with infection prevention and control measures did not always ensure patient safety. Managers were not always aware of poor practice.
- Processes to ensure patients' safety were not always followed in the operating theatre.
- Department managers did not check systems to ensure emergency equipment and medicines were safe and fit for purpose.
- There was a lack of training and awareness with regards to emergency scenarios.

However:

- Incidents were reported and dealt with appropriately and trends and actions to minimise risks were communicated to staff.
- Patient areas were visibly clean and tidy.
- Patients were assessed, treated and cared for in line with professional guidance.
- There were effective arrangements in place to monitor and manage pain.
- Patient surgical outcomes were monitored and reviewed through formal national and local audit.
- There was sufficient competent medical and nursing staff on duty to meet the needs of patients.
- Nursing, medical and other healthcare professionals were caring.
- Patients were positive about their care and experiences and were treated with dignity and respect.
- Complaints were acknowledged, investigated and responded to in a timely manner. Information about the hospitals complaints procedure was available for patients and their relatives.
- The service reviewed and acted on feedback about the quality of care received.

Are surgery services safe?

Requires improvement

We found that surgery services required improvement, because:

- Systems, processes and standard operating procedures were not always reliable or followed to keep people safe.
- Infection prevention and control measures did not ensure patient safety. Operating theatre staff did not use the correct theatre attire, including gowns and footwear, when leaving and returning to theatre from other areas of the hospital, or always clean their hands when entering and leaving the department.
- Storage of equipment was not well organised on the wards, with no indication what had been cleaned or maintained, to ensure it was fit for purpose.
- Checks of resuscitation equipment and drug fridges were not carried out in accordance with the hospitals own policies.
- The 'Five steps to safer surgery' were used. However the principle behind taking time out before commencing surgery was not fully practiced with all staff present and participating.
- There was no local protocol for the management of changes to operating lists as specified in the hospitals operational policy for operating theatres.
- Senior nursing staff had limited or no knowledge of the main items on the hospital's risk register.
- The folder used to provide information about key on call personnel and dealing with a major incident was out of date, by several years and there had been no scenarios or training for staff to deal with a non-clinical major incident.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was monitoring and reviewing of activity to enable staff to identify and understand risks. Staff understood their responsibilities in ensuring a Duty of Candour ensuring patients were kept informed of near miss and actual incidents that involved them.
- Staffing levels and skill mix were planned, implemented and reviewed.

- When something went wrong, there was an appropriate investigation that involved relevant staff and lessons learned were communicated promptly to support improvement.
- There were systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. These were understood by staff.
- A National Early Warning Score (NEWS) was used to identify deteriorating patients.
- There were effective handovers between shift changes, to ensure staff could provide safe and appropriate care.
- Risks to people, who use services were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and medical emergencies.
- Plans were in place to respond to emergency situations.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them internally and externally.
- There were no reported incidents of a never event or serious incidents in the reporting period October 2014 to September 2015. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong, systemic, protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Incidents were recorded using an electronic reporting system. Staff received training at their induction to learn how to correctly use the system. They understood their responsibilities about reporting incidents and were aware of the types of situations where incident reports should be completed including near-misses. Senior staff would log incidents for temporary staff that did not have access to the system.
- There had been 594 clinical incidents reported between October 2014 to September 2015. The number of incidents per month as a percentage of admissions varied, 4% to 10%, which is in line with the national average. A significant number of the incidents related to cancellations on the day of admission, prior to surgery taking place, due to clinical and non-clinical reasons and patients who did not attend (DNA,) for appointments or admission. For example, there had been 71 incidents reported, of these 20 related to cancellations on the day of the operation due to staffing in endoscopy, 13 incidents related to DNAs and two incidents were day case patients that stayed overnight.
- Feedback to staff was varied, but most confirmed they did receive some feedback about incidents relevant to their department and this was evident from minutes of staff meetings.
- Nursing staff described an example of how a multidisciplinary approach was used, when an incident occurred where a patient received the incorrect bladder irrigation fluid. As a consequence the team, including ward staff, theatre staff and porters reviewed how fluids were stored, to minimise the wrong fluid being selected. In addition the checking process was reinforced, prior to administration of irrigation fluid. There was evidence of duty of candour being applied in the patient notes regarding this incident.
- Staff understood their responsibilities with regard to the duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of a hospital risk register but senior nurses we spoke with were unaware what the main items on the register were. This meant they were unable to take measures to minimise risks.
- Mortality rates were reported in the annual quality report and if an incident occurred it was reviewed at the hospital's clinical governance and medical advisory committee (MAC) meetings. There had been no deaths in the reporting period October 2014 to September 2015.
- The hospital gathered patient information, such as hospital acquired infections and reviewed these through its clinical governance processes. This information was displayed on staff notice boards and on the hospital website. There was a detailed quality report for the period April 2014 to March 2015 that patients could access via the website. Hard copies were available to the public in the hospital. It contained details of all quality measures such as infection rates, satisfaction rates and serious incidents. There had been no reported infections, including those related to intravenous catheters and there had been no reported incidents of pressure ulcers or falls during the reporting period.

- There had been six incidents of hospital acquired venous thromboembolism (VTE) of pulmonary embolism in the reporting period. All patients were risk assessed for VTE and completion of risk assessments were audited which showed compliance was above 95%. VTE audit was conducted on a monthly basis with results being discussed at department meetings and reported to the clinical governance team.

Cleanliness, infection control and hygiene

- There were systems in place to prevent and protect people from a healthcare associated infection; however, these were not always followed.
- The hospital had policies and procedures in place to manage infection prevention and control. Nursing and medical staff had access to a microbiologist when required
- We observed lack of compliance by some theatre staff with regard to the correct use of theatre attire including covering 'scrubs' and changing footwear when leaving and returning to theatre from other areas of the hospital. Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Peri Operative Practice state there must be arrangements made to ensure that there is a sufficient supply of clean cover gowns available. In addition, footwear worn in theatres should be for that use only. Cover gowns were provided but not always worn and footwear was not changed when leaving the department and re-entering the operating theatre. When we raised this with the senior management team, they immediately put an action plan into place, to stop this practice. During the unannounced inspection we saw there were notices displayed on theatre doors advising staff about restricted access. However, as the new process had not been fully embedded we saw three staff who were not complying with the new process, but acknowledged that a new way of working would take more time to implement.
- We observed correct hand hygiene being practised by staff in the ward areas although this was intermittently practiced by staff in the theatre department. Hand hygiene audits conducted in the reporting period October 2014 to September 2015 showed a compliance of 98%. We raised this with the senior management team, who immediately placed posters at the theatre entrances and were planning to obtain staff signatures on policy documents to ensure all were aware of the need to comply.
- The ward and operating theatre areas appeared clean. There was an allocated housekeeper who was responsible for maintaining the daily cleaning tasks, including deep cleans where required. Clinical deep cleans of the operating theatre department were undertaken by an external company and certificates were provided on completion. A daily checklist was used to ensure all aspects of required cleaning were met.
- The patient led assessment of the care environment (PLACE) results regarding cleanliness showed a patient satisfaction level of 99% for 2015.
- Servicing of ventilation and filters was undertaken by the service engineer at appropriate intervals.
- There was an annual infection prevention and control work plan in place which was managed by the infection prevention and control lead nurse. There were meetings, and minutes of these were circulated to all relevant staff groups and governance committees. There was an infection control link nurse who had a job description to clarify the duties required of a link nurse.
- Patients were screened for MRSA pre operatively using the same criteria as the local trust as the hospital treated NHS patients. There had been no reported incidents of hospital acquired MRSA. There had been one case of Clostridium difficile during the report period October 2014 to September 2015; however this was not hospital acquired.
- The operating theatre department was found to be clean and tidy and the daily cleaning records were consistently completed.
- Staff were observed to use personal protective equipment when required, such as goggles/visors, aprons and gloves.
- Endoscopes were safely managed and leak tests performed. The endoscopy service had achieved accreditation by the Joint Advisory Group on gastrointestinal endoscopy which operates within the care quality improvement programme of the Royal College of Physicians. This requires the hospital to meet specific standards regarding the cleaning and decontamination and storage of endoscopes.

- There were three reported incidents of surgical site infections. Each incident had been reviewed by the relevant admitting consultant and treatment provided as required. No trends were identified.

Environment and equipment

- The storage and use of equipment did not always keep patients safe.
- Storage of equipment was not well organised on the wards with no indication what had been cleaned or maintained to ensure it was fit for purpose.
- There were resuscitation trolleys on each ward and in the operating theatre department. Checklists for checking the contents of the trolleys had not been completed on the wards on 13 occasions in the past two months prior to the inspection. This matter was brought to the attention of the ward sister and ward manager as this was not in accordance with the hospitals resuscitation policy which states; 'The manager responsible for the area will audit on a monthly basis that the resuscitation trolleys checks have taken place and any discrepancies actioned'. During the unannounced inspection we saw the checks had been completed and recorded in accordance with the hospitals resuscitation policy.
- Resuscitation medicines were not stored in the locked trolley but in tamperproof bags supplied by pharmacy. There were checks made that bags were sealed and all bags were opened once a month to check the contents were in date.
- Other resuscitation equipment such as oxygen and suction machines were found to be clean, complete and in working order. We saw portable equipment such as electrocardiograph and suction machines had recently been labelled as tested and safe for use.
- In the operating theatre there was a difficult airway intubation trolley. The intubating laryngoscope stored on top of trolley had been decontaminated but there was no method to identify when it should be re-processed.
- The changing rooms in the operating theatres were small. We saw theatre scrubs and shoes stored untidily and it was unclear which were clean and which were dirty.
- Daily checks of anaesthetic equipment was completed and recorded.

Medicines

- Medicines were stored securely in accordance with regulatory requirements.
- Fridge temperatures for storing fluids and medicines were not always checked every day. There were significant gaps of four to five days at a time in the checking and recording of the medicines fridge temperatures during the previous two months prior to the inspection. Monthly sign offs, by the manager, in line with policy, were also not completed. This meant that the fluids and medicines may not be safe to use. This matter was brought to the attention of the ward manager. On the unannounced inspection we saw daily checks had been completed and recorded.
- Nursing staff were unclear about what actions they should take if a drug fridge temperature was outside the specified range.
- We checked the records and completed random reconciliation checks of controlled drugs on the ward and in the operating theatre department. These were found to be correct.
- There were effective arrangements for the receipt, storage, dispensing and disposal of unwanted medicines managed by the pharmacist.
- The pharmacist checked and maintained agreed stock levels and ensured there was appropriate stock rotation. In addition, the pharmacist checked all the patients' medicine charts daily, to ensure there were no prescribing errors or contraindication. An audit of prescribing errors was undertaken and reported via the clinical governance and MAC meetings.
- Allergies were recorded clearly on the medicines record.
- Nursing staff were aware of and able to easily access guidance such as the hospital's medicines policy and up to date British National Formularies.
- There was a policy for the use and management of unlicensed medicines. The term unlicensed applies to those medicines which do not have a UK marketing authorisation granted by the medicines and healthcare products regulatory agency (MHRA). These medicines may be used when there is no other effective or safe alternative. The policy required consultants with practising privileges to make a formal application to the MAC for the use of such medicines. We saw a record of unlicensed medicine use in the pharmacy.

- We observed routine oral and intravenous drugs being given. Staff washed their hands prior to preparation of medicines and appropriate checks were made prior to administration to ensure the correct patient received the correct medicine.
- We checked medicine records and were able to see all entries were signed and dated.
- Prior to discharge home patients were reviewed and prescribed any medicines required for their continuing care to take home with them. Nursing staff told us an explanation of the medicines was given to the patient when handing them over to ensure patients understood how to use the medicines safely and effectively. Details of such medicines were communicated to the patients General Practitioner in the patient's discharge summary.

Records

- The hospital used a paper based records system for recording patients care and treatment. Patient's medical records were stored securely in the ward office, and care plans and observation charts were stored in covered files inside the patient's room to ensure privacy and confidentiality.
- We looked at six patient medical records. A complete set of all aspects of patient care and treatment were kept on site including a record of the initial consultation and treatment provided by the admitting consultant.
- The records contained information of the patient's journey through the hospital including pre assessment, investigations pathology results and treatment and care provided. The patient details were visible on each page. Entries were signed and dated.
- The care pathways used included risk assessments such as risk of falls and mobility, which were found to have been correctly completed and reviewed as required.
- Some patient records were kept at the bedside, such as care plans and fluid balance charts and these were found to have been completed and up to date.
- Anaesthetists had recorded their assessment on the anaesthetic sheet including the patient's height and weight and American Society of Anaesthesiologists (ASA) Physical Status classification score.
- Theatre records were completed and including the five steps to safer surgery checklist. The five steps to safer surgery checklist was audited which showed a high level of compliance (13 of 15 records audited were fully compliant). However, audits were undertaken of the paper record only. The process itself was not audited and we observed in the operating theatre, that not all staff took part in the whole process, which was against the essence of the checklist.
- A records clerk was employed to effectively manage the records to ensure they were available as required, for example to ensure files were available on site for clinic appointments or following a patient re admission. The most recent records were stored on site and older records were scanned onto the hospitals electronic database and archived by an external company prior to being destroyed.
- There was a records management policy which was due to be reviewed in March 2015. To ensure compliance audits were completed against the policy standards. We saw evidence of quarterly audits being completed in 2015, with compliance rates rising from 66% to 91% against audit standards using a sample size of ten sets of notes for each cycle. This was part of a clinical score card and there were action plans in place to ensure improvements.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse and avoidable harm that reflected relevant legislation and local requirements.
- Nursing staff we spoke with had a good understanding of safeguarding; they had received training and were able to describe how they would respond if they had a concern. The nursing staff could name the respective adult and child safeguarding leads.
- Non-clinical staff underwent level one child and adult safeguarding training, clinical staff received level two and the safeguarding leads received level three training. We saw from the hospital's training records that 93% of staff had undergone safeguarding training.
- The hospital had a registered nurse (child branch) who was the named safeguarding lead.
- Information about a chaperone service was displayed and how this could be was accessed by patients on request.
- There had been no safeguarding concerns reported during the reporting period October 2014 to September 2015.

Mandatory training

- Mandatory training was provided for staff both face to face and via electronic learning.

- Face to face teaching included training for blood transfusion for all staff who took part in any stage of the process, manual handling, clinical paediatric basic life support, clinical antiseptic non-touch technique, hand hygiene, customer service excellence, manual handling theory, fire safety and adult basic life support. These sessions were held monthly for staff to access and attend.
- Heads of department and were responsible for ensuring compliance and were able to view electronically, each staff member's level of compliance and see when annual updates were due for completion.
- Staff were authorised to completed electronic mandatory training within quiet periods at work, or alternatively were offered the option to remotely connect to the training at home and receive payment for their time.
- Generally mandatory training records for the wards showed a compliance level between 86% and 96%. The lower score was due to non-attendance due to sickness. The operating theatres similarly had compliance levels between 88%-97% compliance.

Assessing and responding to patient risk

- A pre-admission assessment was completed for all patients prior to their admission to hospital for treatment. Patients were either pre assessed at the hospital or by telephone. The pre assessment team told us they felt supported by, and worked closely with, the consultant anaesthetists, if they identified any concerns about a patient's condition or fitness for surgery.
- When patients were booked for treatment following consultation they were asked to complete a questionnaire. This helped staff determine the level of pre assessment required for example, if a telephone assessment would suffice, or whether they required a full one to one assessment, for example, patients being admitted for major surgery.
- Patients identified with several co morbidities and classified as ASA 3 and above were routinely referred to an anaesthetist in accordance with the hospitals pre admission policy. The resident medical officer (RMO) was responsible for reviewing electrocardiographs to identify any abnormalities as part of the pre admission process. We observed these checks were completed during the inspection.
- A National Early Warning system (NEWS) tool was used to identify deteriorating patients. This system alerted nursing staff to escalate, according to a written protocol, any patient whose routine vital signs fell out of safe parameters. We reviewed six patient charts and saw these had been correctly completed.
- The 'Five steps to safer surgery checklist' was used. We observed checks as they were carried out. Not all staff were observed to be concentrating on the process and listen to all responses, they simply answered their part of the process, then returned to their own duties. For example the scrub nurse continued with other duties preparing the patient, and the operating department practitioner was not present. This meant that the principle behind taking time out before commencing surgery was not fully practiced. Monthly audit results of the different stages of the five steps to safer surgery for the period January to December 2015 varied between 70% and 96% compliance. We saw evidence compliance was discussed at medical advisory committee meetings where consultants were reminded of the importance of ensuring each stage of the process was completed to ensure patient safety.
- There were appropriate arrangements for ensuring blood required for elective surgery was available when required, and for obtaining blood in an emergency. There was access to the minimum requirement of two units of emergency supplies of O Rhesus negative blood. The blood fridge temperature and stock were checked and recorded daily.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by the RMO and if necessary reassessed by the admitting consultant or anaesthetist where required.
- There was a formal arrangement for patients to be transferred to the local NHS hospital if the patient required critical care to level two or level three. These are critically ill patients, who require either organ support or closer monitoring in the immediate post-operative period. There had been 21 transfers out of the hospital for various reasons between October 2014 and September 2015. This is in line with national averages. All transfers out of the hospital were treated as a clinical incident and fully investigated. We considered all the transfers and found that there were no trends an all transfers had been investigated and scrutinised at clinic governance and MAC meetings.

Requires improvement

Surgery

- The hospital had a two bed unit to care for patients who required level one nursing care and observation. Patients were pre-booked to ensure the appropriate staff were available to monitor the patient.
- Patients with known allergies wore a red identification bracelet, which acted as an alert to any staff providing care or treatment.
- There were alarm systems to alert medical and nursing staff when immediate assistance was required in the case of an emergency.
- There was guidance for staff about how to respond to incidents of major haemorrhage and scenario training had been used relating to this.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday. Staff had access to the contact details of consultants providing cover and were aware where this could be found.
- The operating theatre team held daily briefing sessions known as safety huddles which we observed in action. These meetings were used for example, to check if all ordered equipment had been received, staffing arrangements and allocated responsibilities were understood. Staff were made aware of any changes to operating lists and there were checks to see if staff had any concerns. We observed a meeting in progress and noted all patients on the operating list were discussed. A lack of equipment was identified for one procedure and the operating list was altered to accommodate this
- If changes to an operating list had to be made there was a process understood by operating theatre and ward staff to ensure the right patient, received the right treatment, at the right time, although there was no local protocol as specified in the hospital's operational policy for operating theatres. Prior to admission patients received a letter advising that they could drink clear fluids up to two hours preoperatively. If the order of the list changed ward staff were advised by the anaesthetist whether patients whose order of operation was changed if they could have clear fluids although nursing staff advised this did not always happen.
- We saw a revised resuscitation policy had been introduced in March 2016. In the event of a cardiac arrest each staff member holding a cardiac bleep attended. Nursing staff explained that although all staff members may not always be required they attended.
- There were five resuscitation trolleys in the hospital.
- Resuscitation scenarios are aligned to real life situations staff may have to manage such as haemorrhage or cardiac arrest. There had been no scenarios been practiced in the past six months. This meant that the policy had not been tested or risk assessed against a scenario.

Nursing staffing

- A formal acuity tool was used to assess dependency. Patients that required one to one or one to two nursing, were staffed separately to the ward staffing levels. Theatre staffing was planned and provided in accordance with The Association for Perioperative Practice (AfPP) guidelines
- The hospital only undertook elective surgery which meant the number of nursing and care staff required on any particular day could be calculated and booked in advance.
- We saw that duty rotas were planned four weeks ahead and reviewed on a daily basis. Changes to rotas were clearly recorded.
- Contracted staff worked flexible hours to cover the rota and gaps were met by a separate team of bank and agency staff familiar with the hospital and team.
- Agency staff were provided with an induction programme when new to the hospital, which included access to and the location of emergency equipment and fire exits. Records of signed completed induction were maintained by the hospital. We spoke with one agency nurse who said that they had found the induction relevant and useful.
- Handovers between staff took place between each shift.
- Some spinal neurosurgical procedures were undertaken. When these procedures were planned, specialist nursing bank staff were booked.
- At the time of the inspection there were four full time equivalent vacancies for health care assistants on the wards. The ward manager explained that they were actively recruiting and were supported by the senior managers, if they escalated concerns about staffing levels.

- There were trained mentors to support and supervise student nurses allocated to the ward.

Surgical staffing

- Patient care was consultant led. The hospital practising privileges agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need or at the request of the matron, hospital manager, or RMO.
- Consultants new to the hospital received a formal induction, and were able to work under practising privileges only for their scope of practice covered within their NHS work.
- For consultants to acquire and maintain practising privileges they had to provide evidence they were fit to practice. Evidence required included current registration with the General Medical Council, indemnity and a current Disclosure and Barring certificate.
- For each application the following information was requested, the actual procedures they wished to perform and the current volumes of each group by procedure performed in their NHS practice. The hospital had an MAC whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practise.
- The MAC reviewed existing practising privileges annually, to ensure continued compliance with the practising privilege agreement and advised the hospital about continuation of practising privileges. If there was non-compliance with practising privileges, the hospital director, would suspend the consultant's privileges so that they were not able to practice at the hospital until all the required information had been given.
- Consultants were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their practicing privileges were renewed.
- There was an up to date out of hours on-call list for consultants. If the consultant was not available the second point of contact was the anaesthetist or a nominated colleague, which had been pre-arranged.
- RMOs were employed through an agency the hospital's parent company had a formal contract with. They worked a one week on one week off rota then handed over to the other RMO.
- Nursing staff and the RMO had found the consultants to be supportive and responsive when they were contacted for advice.
- To ensure effective planning and continuity of service consultants were required to provide the hospital a minimum of six weeks' notice of leave such as holidays.
- Up to date contact numbers for consultants were available to nursing staff in wards and operating theatres and we saw that there were formal cover arrangements for when consultants were away and unable to be available for their patients.
- If the consultant wished to use external staff as a first assistant the protocol required adequate notice was provided to allow time for all identity, fitness to practise and competency checks to be made to ensure patient safety.

Major incident awareness and training

- We spoke with nursing staff about arrangements they had to respond to major incidents. They had a folder on the ward which contained a Business Continuity Plan. This policy contained instructions and guidance for staff to use for the various scenarios they may have to respond to such as fire, flooding, medical emergencies, bomb threats or chemical emergencies. The policy also contained contact details for on call, senior staff and utility companies, but these had not been updated since 2013.
- There was also guidance for staff about how to respond to clinical incidents of major haemorrhage and scenario training had been used relating to this. However, there had been no major incident training or scenarios with regards to non-clinical incidents, for example, loss of power or fire.
- At reception there was a folder which remained there whilst reception was open, but was taken to the ward when reception closed. This folder was said to be used in when on call staff were required and if there was a major incident. It contained a Ramsay Business Continuity Plan dated September 2011, which was due to be reviewed in March 2014. Within the policy there were a number of flow charts to be used in the event of an emergency, for example, flood, fire, and medical emergencies. The emergency contact details were dated August 2011. There were a number of handwritten entries, however, it was unclear when these were added. We brought this to the attention of the senior managers, who agreed to update it straightway.

Requires improvement

Surgery

Are surgery services effective?

Good

We found that surgery services were effective because:

- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patient's needs were assessed taking account of their physical, clinical and mental health.
- Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.
- Staff were qualified and had the skills they needed to carry out their role effectively.
- Staff were supported to deliver effective care through appraisal and reflective practice.
- Staff could access the information they needed to assess, plan and deliver care to patients in a timely was and there were secure systems to manage care records.
- Consent to care and treatment was obtained in line with legislation and guidance.

However, we found that:

- There was participation in relevant local and national audits, including clinical audits and other monitoring such as benchmarking and service accreditation, but there was not always accompanying action plans to support improvement in the case of local audits.

Evidence-based care and treatment

- Policies were accessible to staff on the hospital intranet and based on professional guidance such as the National Institute of Health and Care Excellence (NICE) guidance and Royal College guidelines. For example the pre assessment policy was based on the 2003 NICE guidelines with regards to pre- operative tests for elective surgery.
- The hospital had a schedule of the frequency audits performed throughout the year, for example, medicines and records. Results were reviewed locally and corporately at clinical governance and MAC meetings then results were cascaded to clinical departments.
- The hospital had systems in place to provide care and treatment in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition of and response to acute illness in adults in hospital.) For example an early warning score system was used to alert staff should a patient's condition start to deteriorate.
- There was an annual infection prevention and control work plan in place which was managed by the infection prevention and control lead nurse and supported by a departmental link nurse. There were quarterly meetings and minutes, circulated to all relevant staff groups and governance committees.
- We saw the January 2016 pre-admission and discharge planning audit which looked at a sample size of ten patients. Overall compliance with the national standards identified for this audit was 94%.
  - There was 0% compliance with the requirement to provide patients with written information prior to admission.
  - 70% of patients were offered the opportunity to leave comments about their hospital stay,
  - 80% of patients had discharge transport arranged prior to admission, and
  - 90% of patients were provided with an approximate time of discharge.
- There were no audit comments or actions identified following this data collection.

Pain relief

- The surgical pathways that were in use, prompted staff to assess and record if pain was being managed effectively. This was commenced in the pre-assessment clinic where actions to deal with pain management were discussed.
- Patients told us nursing and medical staff were responsive to requests for pain relief and monitored the effectiveness of medicines provided.
- In January 2016 new competencies for nursing staff were introduced in addition to the current mandatory competencies. This included pain management to ensure staff could meet the standards specified in the hospitals pain management policy and correctly use pain assessment tools. The hospital had a pain assessment tool and analgesia ladder standard operating procedure which had been issued in July 2013 and was due for review in June 2016, this provided guidance to staff to manage patient's pain. This document did not reference any best practice national guidance.

- The post-operative pain management policy provided a pain assessment score, grading the patient's pain score from green through to red, with associated guidance for staff to follow. This policy had been issued in 2014 and was due for review in 2017.
- There were no audits of the effectiveness of pain relief.

Nutrition and hydration

- The pre assessment questionnaire for patients included questions to identify if patients had specific dietary requirements, which along with any reported food allergies were recorded on the care pathway.
- Pre operatively patients were allowed to drink water up to two hours prior to anaesthetic in accordance with the hospital policy which reflected guidance by The Association of Anaesthetists of Great Britain and Ireland (2010) "Pre-operative Assessment and Patient Preparation."

Patient outcomes

- Patient Reported Outcome Measures (PROMS) such as the use of EuroQol-5D and EQ Vas index for knee replacements showed the hospital was in range with the England average score. EQ-VAS is a visual analogue score. Patients mark on a chart their current health status, zero being the worst possible state and 100 being the best possible. The majority of patients reported an improvement in health, and results were better than the England average for the Oxford Knee Score. These measures are based on descriptive information relating to five areas; mobility, self-care, usual activities, pain or discomfort and anxiety or depression.
- There were low rates of unplanned transfers to another hospital during the reporting period October 2014 to September 2015. They were reported as 0.1% to 0.3% per 100 patient discharges. There was a similar pattern for unplanned readmissions within 29 days of discharge. There had been 13 unplanned readmissions between July 2014 and June 2015 which equated to 0.1% per 100 patient discharges.
- The hospital participated in national audits such as National Joint Registry and National Comparative Audit of Blood transfusion. Compliance with these audits was overseen by the corporate and local clinical governance teams.

Competent staff

- At the time of the inspection, appraisals had not been completed for all staff in the operating theatre; this was mainly due to recent appointment of a new theatre manager. However we saw appraisals had been completed annually and the hospital achieved 100% completion for the majority of staff in the previous year.
- Nursing staff, who had received an appraisal, explained how they were required to complete a self-assessment which they returned to their manager prior to their appointment. This allowed the manager to effectively plan the appraisal. We spoke with some staff that had completed their appraisal. They told us they set their own learning needs and had found the process supportive.
- There was a set of mandatory competencies for nursing staff to achieve, for example, pain management. The care of patients with epidurals had not been assessed, but work had commenced to rectify this. Staff in recovery had completed their paediatric immediate life support training but had yet to complete their competencies.
- Nursing staff explained that all staff who administered medicines had to have their competency assessed annually to calculate and administer medicines. We saw that medicine competencies were up to date. In addition any agency staff had their competencies undertaken by their agency. The staff had received coaching from the resuscitation lead sister who coached all the staff, and the hospital was proud that they had achieved the highest pass rate in the company.
- The nurses providing the pre assessment service had attended a two day course about pre assessment.
- There was a process for checking and following up professional registrations, for example General Medical Council, Health and Care Professionals Council and Nursing and Midwifery Council. We checked a sample and saw that these were all up to date.
- The role of the MAC included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for a consultant to carry out specified procedures according to their individual scope of practice.
- There were arrangements which required the consultant to apply to undertake a new technique or procedure not done previously by a practitioner at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which took specialist

advice, if required, such as that of NICE. The practitioner was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure.

- Practicing privileges for consultants were reviewed annually. As well as ensuring that General Medical Council registration and indemnity insurance policies were up to date, the review included all aspects of a consultants' performance, including a review of their annual appraisal, volume and scope of activity plus any related incidents and complaints.
- If a consultant did not comply with these requirements, their practising privileges were suspended, meaning they could not see or admit patients.
- Surgeons sometimes brought their own surgical assistants with them to the hospital. When this happened all the necessary checks were completed to ensure the assistant was safe and qualified to practice. First assistant training had been completed for some staff in the operating theatre.
- Agency staff were provided with an induction and orientation to the hospital. We saw records of completed inductions. The agency nurse employed in the operating department had completed competencies to use equipment in endoscopy and administer intravenous medicines.
- The RMO carried an arrest bleep had completed advanced life support training although had not attended a practice scenario.
- At the time of the inspection all ward nursing staff had completed the basic life support course and five had completed the immediate life support course and attended an Acute Illness Management (AIMS) course. There was one nursing staff member who had completed advanced life support training in addition to the RMO
- Staff received training about how to correctly use NEWS and calculate the patient's score, so that the correct response was made should a patient deteriorate.
- The hospital supported student nurse placements and three nursing staff on the wards were trained to provide mentorship. We spoke with one student nurse who told us they had received excellent support.

Multidisciplinary working

- Staff providing the pre assessment service were supported by the medical team when they identified concerns about a patient's fitness for surgery and valued a good working relationship with the consultant anaesthetists.
- There was an informal, verbal handover between RMOs about items such as abnormal blood results. The handover tended to be brief as this usually took place near the weekend when the patient occupancy was low. The RMO found the consultants approachable and helpful when further advice was needed and had no problem contacting them when required.
- The clinical multidisciplinary team took part in reflective feedback sessions, the nursing staff explained they would select a recent clinical incident to identify what worked, what didn't and what aspects of care needed to be improved.
- There was evidence of internal MDT meetings to review orthopaedic patients.
- Medical and nursing staff reported good working arrangements and relationships with the local NHS hospital.

Seven-day services

- The hospital undertook elective surgery only with lists planned in advance six days a week.
- Consultants were on call 24 hours a day for patients in their care.
- There was 24 hour RMO cover in the hospital to provide clinical support to surgeons, staff and patients.
- The hospital had on call arrangements for radiology and physiotherapy.
- During out of hours a pharmacist was available to contact for advice and if a prescribed medicine was not available on the ward the RMO could access the pharmacy with a nurse present.

Access to information

- There were arrangements to ensure staff had necessary information to deliver effective care. Staff had access to patient records of those patients treated within recent months should a patient be readmitted. There were arrangements to ensure staff had access to NHS notes for patients receiving treatment commissioned by the NHS. This meant when a patient was admitted for surgery clinicians had all the necessary information available, such as test results.

- Staff were able to demonstrate how they could access to policies and protocols on the hospital intranet. In addition there were paper copies of key policies for agency staff to refer to, as they did not have access to the hospital intranet.
- Copies of minutes of recent meetings relevant to staff were displayed in the ward and theatre offices and rest rooms.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a consent policy. To ensure compliance with the consent policy audits were completed against the policy standards. We saw evidence of quarterly audits being completed in 2015 with compliance rates rising from 60% to 88% against audit standards using a sample size of ten sets of notes for each cycle. However, there were no action plans available to effect improvements.
- We looked at six sets of notes and saw consent forms were fully completed, signed and dated by the consultant and patient. The forms identified the planned treatment, intent of treatment and the associated risks and benefits.
- Nursing staff we spoke with were clear about their responsibilities in relation to gaining consent from patients. During the inspection a pre-operative check was completed by the ward nurse for a patient due to go to the operating theatre and it was found the consent form was incomplete. The admitting consultant attended the ward to rectify this.
- The mandatory training provided to staff for safeguarding included information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) to ensure staff were competent to meet patient needs and protect their rights where required. Only the hospital matron and the quality improvement lead were trained to carry out MCA assessments on patients at the time of our inspection. There were no DoLS requested or in place at the time of the inspection.

Are surgery services caring?

Good

We found that surgery services were caring because:

- Patients were supported, treated with dignity and respect, and were involved in planning their treatment and care.
- Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- Patients understood their care, treatment and condition and associated costs where applicable prior to treatment.
- Patients were communicated with and received information in a way that they could understand.
- There were appropriate arrangements to support and meet patients' emotional needs.

Compassionate care

- Privacy and dignity was well preserved at each stage of the patient's journey. Staff knocked on doors before entering in respect of patient's privacy and introduced themselves. Gowns were provided when patients walked to the operating theatre to ensure their dignity was protected. Once patients were taken to the recovery department curtains were used to ensure their privacy
- A caring attitude was displayed by staff. In the theatre department we observed kindness and reassurance from nursing staff and the anaesthetist took plenty of time to explain and reassure the patient prior to providing treatment.
- Patients told us they saw a nurse regularly on their admission and that everything was explained about what was to happen they were when admitted to their room. They explained this made them feel safe and they valued the frequent checks by care staff.
- Patients spoke warmly about the caring approach and thoroughness of the nursing staff.
- The Friends and Family Test (FFT) survey results for the period April 2015 to September 2015 which had a response rate of 55% increasing to 98% showed an overall satisfaction score of 99%.
- The hospital's PLACE scores were higher than the England average for privacy and dignity they were 96%, and the national average was 87%.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understand their care, treatment and condition and recognised when patients needed additional support.

Requires improvement

Surgery

- Patient's specific needs were identified during the pre-assessment, such as if a patient required an interpreter or required support with their mobility. In addition, they were allocated a named nurse on admission who managed the admission process and supported the patient during their initial pre and post-operative period. This was so that the named nurse could respond to patient's individual needs.
- Patients were orientated to their rooms by the ward administrator, on admission, to help them become familiar with the room and services available.
- Patients told us staff were thorough in the checks made before they had treatment. They felt most of their questions had been answered during the pre-admission process, where the planned discharge date was discussed.
- In a survey of NHS patients treated for pain at the hospital, patients were asked if they were satisfied with the amount of involvement they had experienced when planning their treatment. 81% of patients were very satisfied or fairly satisfied with their involvement

Emotional support

- Pre admission assessments included consideration of patient's emotional well -being.
- Patients felt staff had time to listen and provided reassurance if they had any concerns.
- There was a list of clergy for staff to contact to meet patients different spiritual needs when required

Are surgery services responsive?

Good

We found that surgery services were responsive because:

- Patients' needs were met through the way the service was organised and delivered.
- The needs of different patients were taken into account when planning and delivering services, for example, on the grounds of age, disability or gender.
- Care and treatment was coordinated with other services and other providers.
- Cancellation of operations had been appropriately responded to minimise the risk and improve the service.
- It was easy for patients to complain or raise a concern. Complaints and concerns were taken seriously, responded to in a timely way and listened to.
- Improvements to the quality of service had been made in response to patient feedback and concerns.

Service planning and delivery to meet the needs of local people

- The booking system was conducive to patient needs. Where possible, patients could select times and dates to suit their family and work commitments.
- Considerations of patient's age and gender and type of operation and equipment required were taken into account. The operating theatre manager explained when approving operating theatre schedules checks were also made to ensure availability of other services such as imaging services. These arrangements were further reviewed at their daily 'huddle' meeting when the admitting consultants and anaesthetists were present.
- The hospital director held a daily morning meeting with heads of departments to assess the hospital activity and identify if there were any particular issues or potential service demands that the departments needed to be aware of and pro-actively respond to.

Access and flow

- The hospital's admission policy and local contracts ensured patients received a pre-operative assessment. All patients were assessed and this meant patients were identified as being safe for surgery and unnecessary cancellations were avoided where possible.
- There had been 103 reported incidents of cancelled operations on the day of admission during the period of January 2015 to December 2015. 103 of these incidents were for clinical reasons, for example the patient was unwell on the day of surgery, others were issues of capacity, patient choice or staffing or equipment availability.
- Anaesthetic clinics had been established to respond to the increased complexity of patients being treated, with the aim of avoiding cancelling operations and providing an improved service. Briefing meetings in the operating department were introduced to complete final checks such as equipment orders to avoid cancellation of operations.
- Staff began planning the patient's discharge during the pre-admission process where they gained an understanding of the patient's specific home circumstances and likely care needs.

Requires improvement

Surgery

- The hospital achieved 100% of referral to treatment times for admitted NHS patients. This measure is about patients beginning treatment within 18 weeks of referral in each month, between October 2014 to September 2015. (The reporting period.) There had been a variable rate of unplanned returns to the theatre (14 cases in the reporting period). This was in line with national trends.
- The pre admission service team explained if a patient with specific needs such as living with dementia or a learning disability, was scheduled to attend the clinic, the appointment time allocated was increased to ensure their needs were met.
- Although the hospital had an advanced monitoring facility, this had to be booked in advance to ensure the appropriately trained staff were available to nurse the patient.
- When patients were prepared for discharge a letter was produced and sent to the patient's general practitioner, within 24 hours, outlining the treatment provided and any medicines prescribed.

Meeting people's individual needs

- The hospital only received planned admissions to ensure all patients were pre assessed. Patients' specific needs such as learning disabilities, other disabilities or mental capacity issues were identified at pre assessment, to ensure appropriate arrangements were made to meet individual patient needs prior to admission.
- There was written information available about most types of planned treatment. Information included details of their planned length of stay, after care in hospital and following discharge to ensure an optimal outcome from their treatment. We saw this in the ward. Patients told us they received information about their procedures and nurses told us it was given to them. However, the January 2016 pre-admission and discharge planning audit which looked at a sample size of ten patients, showed that there was 0% compliance with the requirement to provide patients with written information prior to admission, although overall compliance with the national standards identified for this audit was 94%.
- Information provided pre operatively described what patients needed to do before and after surgery to ensure a desired outcome. For example to stop smoking before anaesthetic and the patients' wound management following surgery, to prevent infections. The information which was date and version controlled also contained details about who to contact if they had any concerns.
- We saw two examples of where appointment and treatment times had been arranged to meet the patient's individual needs.
- To address the increase in hip and knee operations, lower limb classes had been introduced, these usually of consisted of eight patients per class. Patients we spoke with gave positive feedback about the service and felt it gave them confidence to manage when they were discharged home.
- Intentional rounding by care staff was completed throughout the patients' stay. This meant patients were visited in their rooms hourly, to check for example, if call bells were in place, a drink was in reach, if the patient had pain or had any other requests.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.
- Patients received written information to take home with them about how to effectively managing their pain after their operation.
- Information provided pre operatively described what patients needed to do before and after surgery to ensure a desired outcome. An example of this was to stop smoking before anaesthetic and wound management following surgery, to prevent infections.
- Details of food allergies and specific dietary requirements were also forwarded to the catering team to ensure they had the information and provisions to meet the patients' needs and ensure their safety.
- Patients attending the hospital for minor procedures were offered a wide choice of refreshments and light meals post operatively.

Learning from complaints and concerns

- The quality improvement lead was responsible for coordinating and ensuring complaints were managed and responded to in accordance with the hospitals complaint policy.
- Their duties included ensuring that the complainant received an acknowledgment within 48 hours of receipt of a complaint using a standard letter. In addition patients received a personalised response within 20 working days, or were kept informed of progress if the investigation was anticipated to take longer.

Requires improvement

Surgery

- Nursing staff explained they tried to resolve complaints quickly at the point of service. Where this was not possible the complaint was referred to their head of department or the quality improvement lead.
- There were information leaflets detailing how a formal complaint could be made. There were also satisfaction forms; 'We Value Your Opinion,' encouraging people to provide feedback about the service.
- Complaints were classed as incidents and reported on the hospitals electronic incident reporting system.
- Complaints were discussed at weekly senior management meetings and reviewed to identify any trends at clinical governance meetings.
- Staff received feedback at departmental meetings about complaints and agreed actions taken to ensure there was shared learning. We saw information displayed for staff on the staff room notice boards, this included the number of complaints received for the month and summary of the actions taken in response.
- Staff were able to describe actions taken in response to complaints such as they had started staggering admission times for patients as there had been complaints about long waiting times for treatment.
- The hospital also had a Hot Alert system. When comments of dissatisfaction were received by the external company managing the patient satisfaction survey, these were forwarded to the hospital manager within 48 hours so they could respond to the patient as soon as possible.
- The hospital ran 'lunch and learn' sessions for staff so that they were aware of what patients had to say about the hospital. However, at the time of the inspection, these had not been held for some months.
- During the reporting period of October 2014 to September 2015 the hospital had received 20 items of feedback on the NHS Choices website as to whether they would recommend the hospital to others. 14 were extremely likely to recommend, one unlikely to recommend and five were extremely unlikely to recommend the hospital.

Are surgery services well-led?

Requires improvement

We rated surgery services required improvement because:

- There was a statement of the hospital's values, based on quality and safety. However we found that staff had limited awareness of this statement.
- There were integrated governance arrangements to minimise risk and ensure shared learning, however these were not always acted upon.
- Staff were unaware of the contents of the risk register so that this could be used effectively.
- There was poor compliance with some infection prevention and control practices of which the senior management team were unaware.
- There were systems in place with regards to checking resuscitation equipment; however, these were carried out intermittently. There was no oversight that this was the case.

However, we found that:

- Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. The leadership actively promoted staff empowerment for new managers appointed, to drive improvement.
- Customer satisfaction surveys responses indicated a high satisfaction with the service. The information used, within surgery for reporting performance, management and delivering quality care was accurate, valid, reliable, timely and relevant.
- Patient's views and concerns were encouraged, and when received were acted on. Information on patient experience was reported and reviewed alongside other performance data. Clinical and internal audit processes functioned well with evidence of actions taken to resolve concerns.

Vision and strategy for this this core service

- There was a clear vision and a strategy to deliver good quality care. However there was a mixed response from staff and consultants regarding their awareness of the hospital's vision and strategy of the service.
- The hospital director explained the hospital's strategy was to develop as an orthopaedic centre of excellence, maintain their Joint Advisory Group JAG accreditation and continue to provide high quality care.
- All the senior team stated that their vision was to be Ramsay's flagship hospital. However, there was no measure for this standard.

- We spoke with various senior staff and consultants. We saw the hospitals values were incorporated into the appraisal process and staff understood the aims to improve quality of service and increase surgical activity.

Governance, risk management and quality measurement for this core service

- There were arrangements in place to ensure that the information used to monitor and manage quality and performance was accurate, valid, reliable, timely and relevant. However, these were not always effective. There was a lack of grip on some aspects of safety, risk and governance.
- The use of the risk register had not been embedded in the organisation and senior staff were unaware of its contents to ensure risks that had been identified were minimised.
- Infection control procedures were not always followed and this had not been identified by the senior team. However, when we indicated this at our feedback session following the inspection, they senior managers were immediately responsive and submitted an action plan to rectify matters. We saw, during our unannounced visit, that items from this had been introduced. Understandably, this had not been fully embedded at our unannounced inspection, but the senior team appeared to be committed to ensuring any outstanding issues were actioned in a timely manner.
- The MAC was attended by a group of consultants who held practising privileges and represented colleagues from each speciality service at Woodland Hospital. Its terms specified membership, quorum and responsibilities, which included review and advising on regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.
- The MAC carried out checks before granting new consultants practising privileges, including checks on their scope of practice to ensure they were only undertaking procedures that they were competent to perform.
- There was a clinical governance (CG) committee which met every other month. Senior department leads attended the governance meetings and were responsible for cascading information back to their departments. The CG committee considered a range of complaints, incidents, health and safety issues and patient satisfaction. In addition, local audits, patient safety and care were included to ensure actions were completed by target dates.
- The hospital had a schedule of audits performed throughout the year showing the frequency of audits, for example, medicines management and records. There was a framework showing how the information should be reviewed and disseminated. Results were reviewed locally at governance meetings and the MAC meetings, and then results were cascaded to clinical departments. However, action plans were not always in place to ensure improvements.
- The January 2016 pre-admission and discharge planning local audit had identified four areas where the hospital was not fully complaint with the national best practice standards such as the National Institute of Health and Care Excellence (NICE), but there was no comment, actions, responsible person or timeframes completed following this audit to ensure service improvement.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS), Friends and Family tests and Patient Led Assessment of the Environment (PLACE).
- The governance processes we saw reflected the hospital's clinical governance policy. This included the requirements to use a standard agenda, and ensure sub committees provided reports, such as infection control committees.
- There was a 100% completion of verification of registration of professional staff with their respective regulatory bodies such as the Nursing and Midwifery Council and the Health and Care Professionals Council.

Leadership / culture of service related to this core service

- Although staff felt they were kept informed about hospital wide developments they felt less confident in some local leadership within the wards. However, the ward senior leaders were new to the hospital and had not had an opportunity to address concerns. We found for example although tasks such as checking resuscitation equipment and medicines storage were delegated there was no system to monitor and ensure tasks were completed.
- Nursing staff were concerned about decisions made about their departments without consultation.

Examples given were occasions when extra patients were added to the operating list without consultation. However, we noted there was no local protocol to effectively manage changes to theatre lists. Another example given was where it had taken several months to get a nurse for the wards with the required skills into post and the manager discovered they had subsequently been deployed to another department without any discussion.

- The new theatre and ward managers both felt able to raise concerns with their managers and felt supported. One example given was the theatre manager had been given full autonomy to reduce theatre lists if they felt they were unsafe.
- We found the theatre manager had created governance systems and action plans to ensure compliance with infection prevention and control practices and cleaning and appointed leads to instigate this. At the time of the inspection staff in the operating department and other staff visiting theatres did not always demonstrate compliance with infection prevention practice, such as failing to clean their hands or change attire when entering the operating theatre. This matter was brought to the theatre manager's attention.

Public and staff engagement

- Woodland Hospital sought feedback from patients, whether they were funded privately or by the NHS via a monthly survey as well as the Friends and Family Test which included simple questions about the quality of the service and whether the patient would recommend it to their friends and family. Feedback was consolidated into a monthly report.
- In addition to department meetings staff received monthly newsletter with their payslip to ensure they were kept informed of new hospital developments**.**

Innovation, improvement and sustainability

- The team safety 'huddle' meetings in the operating theatres had been introduced to ensure a safe and effective service.
- The operating theatre and ward manager told us they were encouraged and supported to put ideas forward that could improve the service and given the autonomy to make changes.
- Woodlands hospital had introduced lower limb classes to cope with an increase in demand and for orthopaedic patients to help improve their outcomes.

Good

Outpatients and diagnostic imaging

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

Information about the service

Woodland Hospital based in Kettering opened in 2009, and had had a major development in 2013 increasing the overall footprint of the hospital. The hospital has12 outpatient consulting rooms, two pre-admission rooms, and two treatment rooms, an onsite pharmacy and x-ray facilities including ultrasound and mobile computerised tomography (CT) and magnetic resonance imaging (MRI) access.

Outpatient services supplied by the hospital include; breast surgery, cardiology, chest physician, colorectal, cosmetics, dermatology, ears nose and throat (ENT), gastroenterology, general physician, general surgery, gynaecology, immunology, maxillofacial surgery, oncology, ophthalmology, orthopaedics, paediatrics, pain control, plastics, podiatry, rheumatology, and urology.

CT and MRI services were provided on set days each week within specialist mobile units, staffed by Ramsay Health Care UK Operations Limited. Staff were not based at Woodland Hospital, but provided these services at various Ramsay Health Care UK Operations Limited locations.

The outpatient department has 12 consulting rooms, two pre-assessment rooms and two treatment rooms which are open from 8am to 8pm Monday to Friday, and then 9:30am to 1pm on Saturdays.

Between October 2014 to September 2015 the outpatient department saw 17,715 new patients which consisted of both NHS and private patients, and 22,553 follow up appointments. 74% of the patients seen in the department were funded by the NHS. 203 children were seen, all on a private basis, 73% of whom were follow-ups.

We spoke with 10 patients, both funded by the NHS and privately and 26 members of staff including nursing staff, consultants, support staff, allied health professionals and managers. We looked at six sets of patient records.

Good

Outpatients and diagnostic imaging

Summary of findings

The overall rating for outpatients and diagnostic imaging services was rated as good for safety, responsiveness and caring. The well-led domain we rated as requiring improvement.

Because:

- Patients spoke very highly of staff, and the majority felt that they were welcomed, treated with dignity and respect, and kept informed of any appointment delays.
- The hospital had provided good disabled access in terms of parking and access around the building, and there were supportive systems in place to assist with patients who were short of sight, hard of hearing or required translation services.
- The radiology department had recently employed a radiology manager, and we also saw evidence of up to date standard operating procedures and quality assurance audits to monitor patient and staff safety.
- Staff were compliant with mandatory training and appraisals. There were systems in place to ensure that medical and nursing staff were supported to check their competencies to achieve their annual revalidation for professional registration.
- The outpatient's team had recently introduced a competency buddying system to aid peer colleagues with the review and sign off of competencies required for their nursing roles, and a reflective practice session which was open to all members of nursing staff on the proviso that they could attend if they contributed to the session. This had been received well by staff.

However;

- Staff we spoke with were unfamiliar with the contents of the risk register. Risks did not reflect causes for concern, within the department, which had been highlighted with our conversations with staff.
- Not all staff were trained to the required level in safeguarding children.
- Audit data collection was taking place but these were corporately led audits and there was no locally driven outpatients audit. There was also no involvement in national clinical audits or reviews. Corporate audits undertaken were not completing the audit cycle by analysing the data, putting actions in place with a responsible lead and timeframe, then re-auditing to monitor improvements.
- Patient survey data demonstrated that some patients were dissatisfied with waiting times for clinics, but there had been no audit or data collection put into place to monitor and service improve this.
- There were different record keeping processes for NHS and private patients, but we were not assured that the relevant staff always had access to full comprehensive documentation for all patients should a medical emergency occur.
- Individual members of staff had very specialist skills which were not being cross covered by colleagues in their absence; we saw evidence of this in both nursing with provision of mental health capacity assessments and within support service teams.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging services as good for safety because;

- We found medical cover for patients to be appropriate. A resident medical officer was available out of core department hours, to aid with medical emergencies, which meant that there was provision of 24 hours a day seven days a week medical cover.
- There was a service level agreement for the transfer of an acutely ill patient to the local NHS hospital, should the need for this arise.
- We saw evidence of radiology standard operating procedures, quality assurance audits and completion of the recommended actions following the 2015 annual radiology protection advisor's (RPA) audit report.
- Hand hygiene audit results across the hospital ranged between 97% to 100% from January 2015 to December 2015.
- We saw documented evidence within patient notes of duty of candour completed.
- Decontamination of equipment was monitored via the sterile services committee and there were two link nurses in place to support this function.
- Adult and paediatric resuscitation trolleys located within the outpatient and diagnostic imaging department received daily safety checks by staff in the department.
- A resident medical officer was available 24 hours per day, to aid with medical emergencies.
- There was a service level agreement for the transfer of an acutely ill patient to the local NHS hospital, should the need for this arise.
- We saw evidence of radiology standard operating procedures, quality assurance audits and completion of the recommended actions following the 2015 annual radiology protection advisor's (RPA) audit report.

However;

- Staff employed by the hospital, who were responsible for assessing children's care in outpatients, did not all have the correct level of safeguarding training.
- We were not assured that all clinical incidents were reported and subsequently investigated.
- There was no e-learning or face-to-face learning for staff in relation to major incidents.

Incidents

- The hospital used an electronic reporting system to record and manage all clinical incidents. All staff received training on induction to enable them to enter details onto the system for investigation. Staff we spoke with understood their responsibility to raise concerns, and record safety incidents and near misses. However, we were not assured that all clinical incidents were reported or investigated. For example, we were told about two 'serious injuries' that had recently occurred. Nursing staff we spoke with within the outpatient department were unable to clarify whether or not these had been reported on the electronic incident reporting system, or not.
- The outpatient and diagnostic imaging services in the hospital had not reported any never events between October 2014 and September 2015. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Imaging services had an on-site radiation protection supervisor 90% of the time who was available via telephone, whilst located at another Ramsay site for the remaining 10% of time. The radiation protection supervisor was supported by annual visits from a radiation protection advisor, ensuring there is always a point of escalation if staff had any safety concerns.
- There had been no 'never events' between October 2014 and September 2015.
- It was confirmed from the radiation protection advisors report that there had been no incidents of patient over-exposure to radiation which required reporting to the Care Quality Commission within the last year.
- None of the nursing staff we asked were aware of the 'duty of candour' regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. However,

they were able to explain to us what they would do if there had been an incident which had resulted in harm for a patient, this would include an explanation, an apology and written notification. The Ramsay group had a corporate policy entitled; 'Being Open Policy' dated October 2015, which we had requested from a senior manager at the time of inspection, but they were unable to locate this. Monitoring of this policy was the responsibility of the Clinical Governance and Risk Management Committees across the Ramsay Health Care UK Operations Limited group by reviewing governance reports from registered managers, matrons, heads of clinical services and responsible individuals.

- Despite the nursing staff we spoke with not being aware of the duty of candour regulation, we saw documented evidence of this being provided to support patients when things had gone wrong. We saw that this candour had been applied when we reviewed incidents and complaints.

Cleanliness, infection control and hygiene

- We saw consultants and staff using hand sanitiser gel as they entered the reception area, and clinical staff were adhering to the bare below the elbows best practice standard.
- Staff received aseptic non-touch technique training for wound care of patients, and intravenous medication administration as part of their training. This was confirmed by the outpatient head of department who was the infection prevention lead within the hospital, and a report contained within the 2014/2015 infection control report.
- Decontamination protocol was monitored by the sterile services committee. The hospital had two identified occupational health link nurses who undertook this role. The sister we spoke with in the outpatient department told us that equipment used within outpatients was predominantly disposable, but for any equipment that required decontamination after use, was sent to the same off site decontamination provider that the theatres used.
- Hand hygiene audits conducted from 2014 to 2015 demonstrated a compliance range between 98% to 99%. In 2015 compliance ranged from 97% to 100%, but these results were hospital wide and not available by department.
- Within the local infection prevention and control environmental audit completed by the outpatient department in November 2015, audit criteria were sourced from healthcare technical memoranda (HTM); HTM 01-01 Decontamination of reusable medical devices, and HTM 61 Flooring, and The Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance.
- The infection prevention and control environmental audit completed in November 2015 demonstrated that there was low compliance within the outpatient area at 67% for general environment. Issues identified were:
  - Lack of space for the dry safe storage of equipment.
  - Availability of cleaning products and instructions.
  - Stock rotation was not taking place.
  - Sluice room shelves and surfaces were not dry and free of extraneous items.
- At the end of these eight audits overall compliance was 89% as was displayed in the staff dining room, but there was no written analysis of results. There were three minor impact actions identified with no responsible individual or timeframe for completion identified.
- We observed a cleaning schedule in an outpatient toilet on 14 March 2016, which showed that cleaning had been scheduled to take place in the morning and afternoon for Mondays to Saturdays. The schedule showed that for six days of that month only one of the two scheduled cleans had been completed, we observed gaps in cleaning schedules in another outpatient toilet.

Environment and equipment

- We saw that: 'I am clean,' green stickers were used within the outpatient department to demonstrate that equipment had been cleaned, and the date this occurred, within consultation rooms.
- The outpatient department used disposable procedural equipment, which removed the need for decontamination processes to be in place, as used equipment was disposed of after each individual treatment.
- Equipment faults were logged and recorded via the hospital's team of maintenance engineers. Simple issues were fixed by the on-site team, but the hospital also held a number of maintenance contracts with external suppliers who would regularly visit to service and monitor specialist equipment such as call bells, and fire extinguishers.

Good

Outpatients and diagnostic imaging

- There was an adult and a paediatric resuscitation trolley available in the outpatient department. We saw that these were regularly checked and the adult trolley was tagged. The paediatric trolley was less secure and was not tagged, but the paediatric nurse we spoke with told us that there were plans in place to upgrade the paediatric trolley to the level of the adult trolley.
- At Woodland Hospital there was a Ramsay diagnostic UK (RDUK) van, which supplied CT and MRI services twice a week in the hospital car park. There was a standard operating procedure (SOP) in place to ensure that a safe, professional, and high quality service was supplied to patients. The SOP was for use by RDUK employees, as well as temporary and sub-contractors of the service. It was the responsibility of the hospital staff to be familiar with this SOP.
- We saw evidence of staff exposure to radiation reports, and were told that the lead vests were checked on an annual basis to ensure staff safety. At the time of inspection two had been taken out of service following concerns about the effectiveness of these through wear and tear.
- The radiography lead confirmed that the hospital did not take part in the imaging services accreditation scheme (ISAS).
- One of the 10 patients we spoke with stated that they had had an extended wait as a piece of equipment had broken down, and they were not sure how long they would have to wait to be seen. They added that they had been offered a hot drink within the waiting area whilst they waited, but they had not received confirmation of what had happened or been given a predicted wait time which they found frustrating.
- None of the consultants at Woodland Hospital brought in their own equipment for outpatient clinics.
- We were concerned in relation to patient's data protection as histology and cytology results were provided in hard copy back to the outpatient department where they were posted in unsecured consultant post trays.

Medicines

- Contrast media was kept locked in a wall mounted cabinet in the x-ray room.
- The on-site pharmacy at Woodland hospital was open from Monday to Friday between 09:00am and 3:30pm and processed private prescriptions. The hospital did not hold or process NHS prescriptions.
- Within the outpatient department blank prescriptions were available via the head of department as these were stored securely within a locked cabinet.
- Senior nursing staff within outpatients confirmed that no Controlled Drugs were used in the department.
- The only medicines stored within the department were those contained within the adult and paediatric resuscitation trolleys. We saw evidence that both trolleys and contents were checked on a daily basis which was recorded; nursing staff told us that the trolley tag on the adult resuscitation trolley was changed on a weekly basis.
- A senior member of outpatient nursing staff told us that the only patient group direction (PGD) used within the department was for the 'flu vaccine.

Records

- There were two main types of records; NHS patient records and private patient records. The NHS patient records were retained by the hospital and accessible to all staff via the hospital electronic system and also via the paper clinic notes that contained nursing and medical notes as well as the National Early Warning Score (NEWS) observation chart, risk assessments, procedure consent forms, and letters to patient's general practitioners.
- Private patients were seen by consultants and their notes were either photocopied for inclusion in the hard copy notes for the hospital's reference. Otherwise these notes were kept electronically by the consultant under their own management software and upon request would be made available to the hospital either via the consultant themselves, or via their secretary who worked offsite.
- Referral letters were filed, any general practitioner communication was filed, as were clinic notes about treatment received.
- Paper copies of patient notes were kept onsite within the health records department. A team of approximately 2.4 WTE staff arranged for notes to be available for clinics, inpatient stays and clinical audits. There were between 3500 and 4500 transactions a month. Older notes were sent to an external company for scanning and storing on the hospital's electronic system, before being destroyed.
- Review of outpatient patient notes demonstrated that notes were legible, up to date and detailed the care and treatment provided to the patient.

- Record keeping audits were completed in radiology to ensure that individual patient's care records were managed in a way that kept people safe. These audits were completed on a quarterly basis, the last results in January 2016 showed 77% compliance with audit criteria, demonstrating a reduction in compliance since July 2015 which had achieved 89%.
- Review of local audits conducted in 2014/15 by the clinical governance committee identified that the completion of consent forms and documentation surrounding the care of the deteriorating patient needed focus within 2015/16.

Safeguarding

- The paediatric safeguarding lead told us that there had been no safeguarding referrals to report in the last six years.
- Non-clinical staff received level one children and adult safeguarding training. Clinical staff received level two training and those in lead roles received level three training. Outpatients and imaging were between 90% to100% compliant with their safeguarding adults and children mandatory training at level two.
- The hospital did not link into the local safeguarding paediatric or adult safeguarding boards, but instead reported and liaised with their clinical commissioning group (CCG) contact, which is usual practice for an independent hospital

Mandatory training

- Mandatory training within the outpatients and diagnostic imaging department was compliant with Ramsay's target, demonstrating between 90% to 100% compliance, the lowest being safeguarding adults at 90%.
- Mandatory training for staff was provided monthly via face to face training There was also some electronic learning for staff to complete either at work or at home.
- Heads of department and administration managers managed staff's compliance with expiry dates for this training. However, there was a training lead, who had an overview of those who required training and they would remind the head of department.
- We saw evidence of an electronic staff record of mandatory training; this listed each of the training courses, the completion date and the due date giving an overall compliance rate at the top of the page for the individual.
- Staff were authorised to complete electronic mandatory training within quiet periods at work in consultation rooms.
- Paediatric basic life support and adult basic life support including defibrillator training were included within the face to face mandatory training days for clinical staff. Administrative staff were trained in adult basic life support.

Assessing and responding to patient risk

- Radiological risk was well managed, and actions identified within the 2015 annual radiation protection advisor's audit report had been completed by February 2016.
- We saw evidence of the national early warning system (NEWS) observation charts used to monitor progress and deterioration of patients.
- We did not see evidence of any risk assessments being completed in relation to specific individual clinical treatment. For example there was no risk assessment for patient allergies or latex gloves.
- The hospital had a service level agreement with a local NHS trust for the transfer of acutely ill patients which had been jointly signed by the Woodland Hospital general manager and the director of finance and information technology at the local NHS trust. Transfer of a critically ill patient into NHS care was the responsibility of the consultant, and upon leaving the hospital ward staff would be responsible for contacting the nurse in charge at the local NHS trust. Woodland Hospital would arrange for the patient transfer and a full hard copy of patient notes for the local NHS trust and the patient would be under the care of the admitting consultant at the acute trust.
- Outside the x-ray room, there was a sign which became illuminated when in use to indicate that radiation exposure was temporarily in use, demonstrating a risk for patients to enter the room at that point.
- The 2015 annual radiation protection (RPA) advisor audit report confirmed that there were relevant radiological risk assessments in place which were aligned to current practice, and that quality assurance checks were completed regularly in accordance with IPEM91 guidance. This report identified five actions for the hospital to complete and at the time of the audit report completion in February 2016 all five actions had been completed.

Good

Outpatients and diagnostic imaging

- All staff within the outpatients department had an in date immediate life support (ILS) certificate.

Nursing staffing

- There was sufficient staff on duty. Where staff were not able to flex to cover gaps in the rota, bank staff were used to cover shifts. These staff were known to the hospital. Staff from agencies were never used in outpatients.
- The outpatient manager and the sister both said that the flexibility of their staff was a real benefit to enable them to meet the needs of the patients. This flexibility allowed for the department not to require the use of agency staff, and when additional cover was required this was provided by long term bank staff, who had received the same induction to the hospital environments as substantive staff.
- An area for development which was identified by the outpatient manager was the need for greater skill mix within the nursing staff team in the department. It was felt that the team would benefit from recruiting nursing staff with medical or surgical experience as vacancies arose. However, no formal skill mix review had taken place.

Medical staffing

- Consultants new to the hospital received a formal induction, and were able to work under practising privileges only for their scope of practice covered within their NHS work.
- Within the outpatient area, consultants were available, within the constraints of their schedule, between 8am and 8pm during the week and 9:30am to 1pm on Saturdays. The outpatient department was closed on Sundays. If consultants were required urgently outside of the core working, for example in the evening or at weekends, then the resident medical officer (RMO) would be available to assess patients and provide simple interventions until the patient could be seen by their consultant. The consultants we spoke with said that they had good working relationships with RMOs.
- The hospital had a regular RMO, who was supported during their rest periods by regular RMOs who each worked for seven days at a time on a 24 hour basis providing medical first response cover for patients when their consultant was not available. The RMOs were provided via a Ramsay contract with an agency.
- There were 70 consultants working within the outpatient department under practicing privileges, none were directly employed by the hospital. Practising privileges is an established process in the independent sector where a medical practitioner is granted permission to work in the private hospital once they have fulfilled certain criteria with regards to the skills and individual competencies.
- Patients we spoke with told us that consultants were approachable.

Major incident awareness and training

- Maintenance staff we spoke to confirmed that there was a major incident policy, but other nursing staff members we spoke to were unaware of any major incident training supplied by the hospital covering either scenario based, or e-learning.
- We saw evidence of a five year business continuity plan in two parts which was due to be reviewed in July 2016. These plans covered eventualities such as loss of key functions such as energy and water, severe weather, bomb threats and explosions, as well as; fire, chemical or medical emergencies. These plans had been reviewed in September 2015 and signed by the general manager, receiving ratification from the information governance committee.
- We saw 'Emergency Management: Fire and personal safety' training was an administrative element of the 'my learning' section of the electronic mandatory training system.
- The Medical Records Management Policy v3 stated that; "A business continuity plan should be in place and must be tested annually to provide protection for medical records which are vital to the continued functioning of the hospital or unit." The general manager and support staff we spoke with confirmed that there was a business continuity plan in place, but without regular scenario based testing there was the risk that emergency procedures would not be familiar to staff. There was no record of scenario training, which according to the policy, should have happened annually.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain in outpatients and diagnostic imaging services was not rated, but we found that:

- There was a radiation protection supervisor available onsite 90% of the working week, and the hospital received annual visits from the radiation protection advisor.
- Radiology conducted quality assurance audits to monitor the safety of equipment and staff protective clothing when using radiation.
- There were internal and external processes in place to ensure that nursing and medical staff completed regular competency checks, appraisal, personal development records and continued professional development in order to achieve annual revalidation for the roles they undertook.
- Infection control local environmental audit criteria were taken from HTM guidance and the Health and Social Care Act 2008.

However;

- The hospital did not participate in any national audits or confidential enquiries, and there was minimal outcome from local audits.
- Provision of service for patients which staff had mental capacity concerns about were limited, however matron stated that work was underway to address this.
- There was limited knowledge within the department about relevant consent and decision making requirements of national guidance including the Mental Capacity Act 2005, and the Children Acts which were last updated in 2004.

Evidence-based care and treatment

- The newly appointed radiology manager was the radiation protection supervisor, and was supported by contact with, annual visits from, the radiation protection advisor who provided the hospital with updates on national guidance relevant to departmental procedures.
- We saw evidence of several radiological quality assurance audits, such as the radiation exposure for x-ray audit which had been completed in February 2016 which showed that the hospital was following best practice national guidance.
- There was a quality assurance radiological audit file which contained results of audits based on localised provider policies conducted on monthly, quarterly and annual basis, these included the following; c-arm audits, equipment exposure tests, calibration tests, and light exposure behind staff imaging desk within the x-ray room.
- We witnessed a number of standard operating procedures (SOPs) some of which referenced national guidance for radiology staff which included; liver biopsy aftercare, MRI algorithm, fluoroscopy procedure and procedure for using mobile intensifier. The majority of these SOPs were within the current date range having been issued in 2014 and due for review in 2017.
- The outpatients and diagnostic imaging departments did not take part in any national audits in 2015 which generally tend to be more medical, surgical or neurologically based, audits undertaken were local. However, within the hospital's 2014/15 quality account the CCG stated that; "The reason for non-participation in national clinical audits and national confidential enquiries is not clear."

Pain relief

- Neither the outpatient's department or the radiology department used patient group directions for pain relief which meant that patients required individual pain assessments and a prescription to be completed before any pain relief could be supplied.
- If a patient was prescribed pain relief as part of pre-assessment or as part of their continuing consultations post procedure, then this could be dispensed via the onsite pharmacy which was opposite the main reception desk of the hospital.
- The hospital had a pain assessment tool and analgesic standard operating procedure which had been issued in July 2013 and was due for review in June 2016, this provided guidance to staff to manage patient's pain. This document did not reference any best practice national guidance.

Patient outcomes

Good

Outpatients and diagnostic imaging

- There was an annual audit plan which was available for staff to access electronically. These audits were medically led, and from our discussions with staff there appeared to have been no attempts to suggest local audits relevant to service improvements or efficiencies.
- There were no audits completed to monitor whether intended patient outcomes were being achieved.
- As part of their NHS portfolio of work, Woodland hospital completed regular patient audits for those attending pain clinics. This formed a CQUIN for the hospital and they supplied quarterly performance audit data to the clinical commissioning group. We saw electronic evidence of two audits completed within the last two months. When we asked the nursing staff if there were any audit reports or presentations made to share the results of the audit, we were told that this did not happen. This was therefore no more than data collection with no analysis or actions assigned to individuals with timeframes occurring following initial data collection, ahead of a re-audit to monitor action efficiencies.
- The radiology manager confirmed that the service was not part of any accreditation scheme.

Competent staff

- Consultants worked under practising privileges and both nursing and medical staff completed annual mandatory training, appraisals, competency checks, personal development reviews and continued professional development to achieve annual revalidation.
- Data supplied by the hospital demonstrated that between October 2014 and September 2015, 100% of nursing and health care assistant (HCA) staff had completed their appraisals.
- Consultants that we spoke to within the outpatient department who worked at the Woodland Hospital, as well as at the local NHS trust, told us that they had completed their mandatory training, appraisals and revalidation via the NHS trust and this was then transposed across to their role within Woodland Hospital. Ramsay policy stated that it was the general manager's responsibility to contact individual consultants three months in advance of their pending expiry of any element of their practising privileges, and the process for re-applying, before review at the medical advisory committee (MAC).
- There was a human resources policy in relation to all staff including consultants obtaining Disclosure and Barring service checks prior to employment or practising privileges being offered.
- Nursing staff within the outpatient department told us that matron was responsible for ensuring that nursing staff were professionally up to date with their knowledge in order to achieve their annual revalidation which formed an element of their professional registration requirements.
- We saw evidence of a new nursing competency review process which had been introduced by the outpatient lead nurse and involved nursing staff being paired in a 'buddy' system, to review each other's knowledge and confidence in a number of clinical situations such as; venepuncture, sharps, and safeguarding, pre-assessment and blood transfusion.
- Nursing revalidation took the form of mandatory training completion, competency checks, personal development plans, continued professional development and clinical supervision. The nursing revalidation process was managed by the matron.
- Nursing staff we spoke with told us that they would not complete outpatient procedures which were outside their own scope of practice.
- Senior managers had discussed the long standing lack of specialist nursing staff. For example there was an infection prevention specialist nurse, and a specialist children's nurse but these skills were individualised and not shared. In an effort to address this we saw the competency process and evidence of individual staff folders containing competency documents. This was a new system that had recently been introduced by the outpatient manager and involved trained nursing staff working in pairs at the beginning or end of shifts to assess each other against key competency standards for clinical procedures. This aided with completing competency assessment, but also was a forum for sharing skills. This process complimented the nursing revalidation process which was managed by matron.
- The senior management team's personal assistant managed the collation and recording of the consultant's documentation for data barring services (DBS), competencies, mandatory training, personal development records (PDR), continued professional development (CPD), and this was provided to the MAC for review.

Good

Outpatients and diagnostic imaging

Multidisciplinary working (related to this core service)

- Staff worked together to assess and plan ongoing care and treatment in a timely way as patients moved through the hospital departments. For example, we saw how the nurses in outpatients interacted with the consultants, the medical secretaries, therapists and the ward, when liaison was required between individual and departments. This meant care was delivered in a coordinated way when different teams or services were involved.
- We saw evidence of discussion about the multi-disciplinary team (MDT) meetings terms of reference, in a paper from February 2016. These terms of reference referred only to internal MDT meetings and did not cover external MDT meetings with other stakeholders involved in patient's care. We saw meeting minutes from the end of February 2016 which demonstrated that the MDT meeting was held in the evening for an hour and discussed five patient cases in the presence of the chair, two surgical consultants, a medical consultant the matron and the minute taker. The February 2015 terms of reference for internal MDTs stated that to be quorate the meeting needed; two operating surgeons and one radiologist. Therefore, this meeting was not quorate.
- An outpatient sister we spoke with confirmed that there were no shared-care pathways in place for patients receiving care on two or more different hospitals sites for which inter-hospital MDT would be required

Seven-day services

- Outpatient and diagnostic imaging services were available six days a week from Monday to Saturday. During weekdays the services were open twelve hours a day from 8am to 8pm, and 9:30am to 1:00pm on Saturdays.
- The pharmacy which was located opposite the main reception offered a five day service which ran from Monday to Friday between the hours of 9am to 3:30pm. However, in practice, the pharmacy opening hours were often longer to cope with demand. Despite an increase in activity, the pharmacy department did not have any more resource. This was discussed with the hospital management team at the time of our feedback.

Access to information

- Diagnostic test results were available to staff via the picture archiving and communication system (PACS), which was used for both NHS and private patients.
- NHS patients seen in the outpatient department had paper notes available for clinics and the electronic patient administration system was also used for this group of patients.
- Private patients seen by consultants had a different system of documentation. Nursing staff and consultants who we spoke with said that often consultants would take private patient notes home with them which was acceptable under their contract of practicing privileges with the hospital.
- There were two systems in place for managing private patient records seen by consultants. The first system involved the consultant keeping their own practice notes and taking a copy of these to be filed in the hospital patient notes, and the second system involved consultant's own electronic systems which were an element of their own private business. In the latter instance, if the hospital urgently needed to obtain copies of the consultant's private electronic notes about a patient, the hospital would contact the consultant's secretary who could provide a copy of the notes required. There was a policy in place to support this.
- If private consultant notes were required out of hours consultants could be contacted directly by the hospital.
- Patients' specimens were collected twice a day and results were reported electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- We spoke to matron about how the hospital would manage a patient who staff were concerned, may lack capacity to make decisions. We were told that the senior management team had acknowledged that an increasing number of these patients were presenting at the hospital and some work needed to be completed to better understand the training requirements for to enable them to assist patients requiring additional support.
- At the time of inspection the provision of mental capacity assessments for patients relied upon a staff member flagging this requirement to matron or the

Good

Outpatients and diagnostic imaging

quality improvement lead who were the only two staff trained to provide these assessments, but we were told that there were plans to increase training to nursing staff for development and competency progression.

- In discussions, staff were not fully confident describing to us relevant consent and decision making requirements of national guidance including the Mental Capacity Act 2005. This was despite mandatory training provided to staff for safeguarding including information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Administration staff we spoke with told us that MCA was mentioned in their e-learning safeguarding mandatory training. However, staff knew that if they were concerned about a patient's decision making abilities, they could contact a senior member of staff.
- We reviewed four sets of outpatient clinic notes, and saw that consent to treatment forms were completed appropriately in all four cases with the initial consent signed by the patient ahead of having their treatment or surgical procedure. On admission, this was followed by a secondary patient signature immediately before their treatment or procedure to ensure that they were fully informed of the risks and potential benefits of the treatment.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging services as good for caring because;

- We received overwhelmingly positive feedback about staff members from patients and relatives we spoke with.
- We witnessed nursing staff responding in a sensitive and appropriate manner to a patient who became distressed whilst waiting for their appointment.
- We heard a couple's positive experience of attending appointments together in order to provide support to each other whilst the patient was undergoing distressing treatment.
- We observed the warm welcomes the reception staff gave to patients registering to see clinical staff for their appointments.

However,:

- We were not assured that vulnerable patients receiving bad news were always sufficiently supported between outpatient visits.

Compassionate care

- We observed reception staff interacting with patients and their relatives in a very warm, respectful and considerate manner, welcoming back patients whom they had previously seen.
- Health care assistants we spoke with spoke of their role of working as chaperones during examinations. They told us how they talked to patients to provide reassurance and distraction for those who were nervous, and ensured that patients undergoing intimate examinations were always appropriately covered before and after examination.
- Patients we spoke with were very complimentary of nursing, medical and support staff including reception staff in the outpatient department. We did not receive any negative comments at all in relation to any of these staff groups. The only negative comment received was in relation to patients being notified in advance of appointment cancellations by the booking team.
- We witnessed a distressed patient within the main outpatient waiting area, and observed the prompt and appropriate response from nursing staff to provide assurance and support. This interaction was conducted in sensitive manner and a private room was sourced in order to maintain the patient's dignity and confidentiality whilst staff talked with the patient.

Understanding and involvement of patients and those close to them

- Patients we spoke with confirmed that they felt able to ask consultants and nursing staff questions about the care they received, and they felt that these were always answered with appropriate detail and sensitivity.
- We heard from a patient who was hard of hearing, and their spouse, how the patient's consultant always welcomed the spouse into the patient's appointment, but ensured that they addressed the patient directly within conversation and faced them directly to allow the patient to lip-read.

Emotional support

Good

Outpatients and diagnostic imaging

- Staff provided emotional support. We observed staff reassuring a patient who was anxious following their meeting with their consultant. Staff found privacy for the patient in a separate area to the waiting room and talked to the patient about their concerns.
- Patient wireless internet connection was provided for patients to be able to access friends, family and social networks whilst at the hospital.
- We were not assured that vulnerable patients receiving bad news were always sufficiently supported and treated between outpatient visits.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatient and diagnostic imaging services as good for being responsive because;

- NHS referral to treatment (RTT) figures were achieved within the national timescales
- A nursing peer competency review system had been piloted with the intention of building upon services offered to patients by utilising nurse-lead services.
- We identified an issue with the maintenance of patient call bells in bathrooms within the outpatient department which we addressed with staff at the time and this had been actioned by calling in an engineer to change all batteries, check all call bells and a daily check was instigated to ensure patient safety.
- Disability accessibility, sight and hearing restricted patients were all supported by aids provided by the hospital, and there was an option for either telephone or face-to-face interpreter support for patients requiring this service.

However;

- Patients we spoke with, complaints we reviewed and the NHS choices website reported frustrations with the appointment booking system.
- Waiting times were an identified issue on the NHS choices website; however both the outpatient and diagnostic imaging departments were not auditing the length of patient waits.
- We could not see any evidence of peer learning taking place from complaints received.

Service planning and delivery to meet the needs of local people

- The outpatients department were collecting data e.g. waiting times, but this data was not being analysed with plans and timeframes in place to make service and patient experience improvements.
- Patients and staff expressed frustrations with the booking process for outpatient appointments, which had changed since the booking manager had left the hospital's employ.
- Three monthly audit data was shared by the hospital with service commissioners, for monitoring purposes as part of the CQUIN programme.
- To aid patients with a mobility problem, there were disabled parking spaces available next to the main reception area. There were two lifts to the first and second floor of the main hospital, and adequate space for manoeuvring in and out of patient bathrooms. In addition, there was a wheelchair ramp from the main reception up to the higher level to enable access to Schofield House, where the physiotherapy department was situated.
- Patients told us that the reception staff would provide a very personal service and came to speak to individual patients, explaining if there was a delay, why this had occurred and giving an indication of how long the patient was likely to need to wait.
- There was a hearing induction loop symbol at the main reception desk; however we did not see this being used by any patients at the time of our visit.
- An elderly patient we spoke with told us they had been seen in outpatient clinic by a consultant and were told that they would receive a follow-up appointment for treatment which they were concerned about, in October to November 2015. The patient had not heard anything until March 2016 when they received their appointment letter for the following day. We spoke with the senior management team about this; they agreed to consider why this had happened.
- Patients we spoke with spoke of frustrations trying to contact a member of staff to speak to about their appointments, particularly about appointments being made at very short notice. We were told that the bookings manager had recently left the hospital, which

had brought about a change in process for booking patients in to be admitted for procedures. The general feeling among staff was that the new method was a more time consuming and process driven.

Access and flow

- For NHS patients the hospital achieved 100% compliance with patients receiving their initial referral into the outpatient department to their treatment being commenced within the 18 week timeframe.
- One patient we spoke to said that they had transferred to Woodland Hospital from their local Ramsay Health Care UK Operations Limited hospital in order to be seen quicker, and despite having a longer journey, had only had to wait three days to be seen.
- Patients we spoke with said that they were often seen within half an hour of arrival. They said that occasionally they had experienced longer waits due to individual patient's needs, but on these occasions the reception staff had kept them informed, and they said that they did not mind waiting.
- Waiting times were not officially recorded within the outpatient's department. However, the head of department (HoD) monitored individual waiting times when they were on duty and if a patient had waited more than 15 minutes, reception staff would be informed so that the patient could be updated. Reception staff confirmed that this was the procedure, and the majority of patients inferred that this was happening but there were two NHS and a private patient who told us that they had not been kept up to date with anticipated waiting times.
- Radiology staff told us that with only one x-ray room, they felt that patients often had to wait for x-ray appointments. The radiology manager told us that magnetic resonance imaging (MRI) appointments could be offered to patients within the same week, but computerised tomography (CT) appointments generally had a two week wait.
- Two of the ten patients we spoke with told us that they had had a number of appointment cancellations and then been given an appointment at very short notice, this affected one elderly patient badly as they said they had been waiting for more than four months to determine whether or not they had cancer. This was raised with the senior managers at the time who assured us that they would investigate.

Meeting people's individual needs

- The patient toilet opposite the nurse's station in the outpatient department had a call-bell, for patient use, within it. We were concerned that at the time of inspection there was a 'test due' date for the year of 2006 attached to the side of it. Nursing staff told us that the maintenance manager regularly serviced the call bells and there was a rolling programme in place. We were unable to view this schedule at the time of inspection due to hospital staff unavailability, so we raised this with a senior manager. On our return to the hospital the following week as part of our unannounced inspection the hospital engineers confirmed that the external engineers had been called to review all the call bells, and replaced all batteries to ensure that these were fit for purpose. They and the general manager advised us that daily call bell checks were in place to ensure the safety of patients with the availability of call bells in clinical areas.
- There was braille on the buttons of the lifts, to aid patients with visual difficulties navigate to the floor they required.
- We spoke with outpatient staff about the number of patients they saw with dementia. Staff told us the numbers were very low, but added that reasonable adjustments were made, such as longer appointment times, and the ability to have a relative or carer attend with them. The hospital's patient-led assessment of the care environment audit showed the hospital was three percent lower than the national average for dementia care at 78%.
- Matron explained that the hospital did not encourage family members of patients for whom English was not their first language, to interpret between the patient and the clinicians, but instead the hospital could offer the services of interpretation services either over the telephone or in person.
- The main radiology rooms within the diagnostic imaging directorate were based on a lower level than the majority of the main hospital building, and these were accessed via a sloping floor, which enabled ease of wheelchair and bed access.
- Within the waiting area of the outpatients department there were a number of patient information leaflets covering a range of clinical procedures, which were available for patients or family members to help themselves to.

Good

Outpatients and diagnostic imaging

Learning from complaints and concerns

- We saw evidence of seven complaints made within the outpatient department for NHS, insurance and self-pay patients from January to December 2015 in relation to orthopaedic clinics, pain, ENT and general surgery and although the numbers of complaints per month were displayed within the staff dining area, we saw no evidence of learning taking place from these complaints.
- Staff told us that changes in practice had occurred as a result of patient complaints received. For example following a complaint, staff were to ensure patients were kept informed when consultant clinics were running late, and information regarding chaperoning had been re-established to ensure that patients were fully aware that they could request a chaperone if they wished.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement for being well-led because;

- Overall senior managers had a lack of grip on governance and service improvement opportunities within the department.
- We saw examples of information being available to staff and managers, but there appeared to be a lack of drive to analyse data collected for service improvement in the case of audits, and a lack of drive to progress visions through to fruition.
- There was no visible evidence of risks receiving regular formal review in order to put in place and monitor mitigating actions.
- There appeared to be limited cross-cover of skills available in nursing and support staff groups, which laid the hospital open to the potential of knowledge gaps in some situations with reliance on individual members of staff.
- Staff were unfamiliar with the five year business continuity plan.
- Some core polices, for example, the records management policy, was 11 months post review date at the time of inspection.
- There was no evidence that the risk register received regular review.
- There was a lack of understanding of governance processes. 'Summary of Consent Audits January – December 2015' related to incident numbers, categorisations and locations and did not contain any information about patient's consent to care and treatment.

However, we found some good practice:

- Support staff, nursing, radiology and consultant staff all spoke very highly of the teamwork and flexibility offered by the team in order to best support patient requirements.
- HoDs held daily meetings to discuss any patient concerns they had for the day so that awareness was shared across the hospital. Staff told us that these meetings were not minuted.

Vision and strategy for this this core service

- The head of department (HoD) for the outpatient department told us that the vision was for the team to have more treatment rooms, which could allow nurses with special interests, such as ophthalmology and gynaecology to expand outpatient services. We did not however, hear of any development proposals made to the senior management team or discussions held about provision of business plans to facilitate this vision.
- The hospital's values were; integrity, ownership, positive spirit, innovation, and teamwork. These were referenced by one member of administration staff that we spoke with.

Governance, risk management and quality measurement for this core service

- Nursing staff confirmed that any new procedures had to be ratified by the medical advisory committee, before they could be approved for use.
- We spoke with nursing staff and asked them if they had implemented any local audits to monitor effectiveness, but they told that audit was medically led. Matron confirmed that there were no outpatient specific local audits and there appeared to be no opportunity or drive to introduce local topics for service improvements.

Good

Outpatients and diagnostic imaging

- We saw two examples of audits from the audit plan. Neither of these were presented in a report or presentation format, but nursing staff told us that results were shared locally in department team meetings. Data was being collected, but appeared not to be analysed, reported upon or action planned against where threshold standards were not met.
- The risk register for the hospital consisted of 14 risks, 13 of which were assigned to the general manager. The majority of these risks had been on the register since 2014 and three had demonstrated risk reduction from inherent, through residual to acceptable levels. One of the risks listed was the potential for nursing call bell failures which had been listed in March 2014, this had originated as a moderate risk and the severity had not changed in two years. We were unable to see evidence of any attempts to mitigate this risk. We raised call bells as a concern with the senior management team as part of this inspection.
- The January 2016 pre-admission and discharge planning local audit had identified four areas where the hospital was not fully complaint with the national best practice standards such as the National Institute of Health and Clinical Excellence (NICE), but there was no comment, actions, responsible person or timeframes completed following this audit to ensure service improvement.
- We were not confident that incidents were thoroughly investigated as there was some confusion amongst staff as to whether or not a serious injury was an incident or not, and we did not see evidence of learning from incidents routinely shared with staff.
- The records management policy was almost a year past review date at the time of inspection, it was due to be reviewed in March 2015, with no evidence of review since its release date in 2012. The policy did not mention consultants working under practising privileges and maintenance of hospital records. This policy stated that there would be regular audits completed against the policy standards. We saw evidence of quarterly audits completed in 2015 with compliance rates rising from 66% to 91% against audit standards using a sample size of ten sets of notes for each cycle.
- We saw that a 'summary of consent audits January to December 2015' paper had been complied. On review the six pages of data which had been broken down by month, we found this was relating to incidents and categories, not consent to care and treatment of patients.
- Nursing staff confirmed that any new procedures had to be ratified by the medical advisory committee, before they could be approved for use.
- We spoke with nursing staff and asked them if they had implemented any local audits to monitor effectiveness, but they told that audit was medically led. Matron confirmed that there were no outpatient specific local audits and there appeared to be no opportunity or drive to introduce local topics for service improvements.
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Leadership / culture of service

- There was a culture that demonstrated some indifference to issues that presented as low risk, but had the potential to deteriorate and increase risk if not addressed.
- Support staff, nursing, radiology and consultant staff all spoke very highly of the teamwork and flexibility offered by the team in order to best support patient requirements.
- HoDs held daily meetings to discuss any patient concerns they had for the day so that awareness was shared across the hospital. Staff told us that these meetings were not minuted.
- Matron and the clinical quality lead had devised in January 2016, a document to record clinical reflective

practice sessions which had been implemented within the outpatient department. Feedback from the HoD was that staff were finding this supportive and beneficial to their professional development.

- There was a lack of awareness amongst staff of the business continuity plans, and there appeared to be no provision of either e-learning, or scenario based training, for staff to feel equipped with how to deal with a major incident.

Public and staff engagement

- The hospital responded to patient feedback on the NHS Choices public website. The overall rating based on 41 feedback results within the last year was three and a half stars out of five (70%). Common themes from the NHS Choices feedback included; consultants having time and empathy for patients, staff having respect and dignity for patients, friendly and helpful staff, cancelled operations, access difficulty for speaking to staff on the telephone, waiting times for appointments. Responses to some of the patient feedback was provided by the hospital's marketing department.
- Staff told us that they regularly received staff newsletters which were attached to their pay slips, and then they were responsible for signing to say they had read this. A log of this was kept by the human resources department. There were no copies of the staff newsletter on notice boards or the staff dining room.

Innovation, improvement and sustainability

- Staff awareness of clinic waiting times was apparent, but there was no formal recording of this by means of data collection or audit, for service improvements.
- Local audits were not being used to monitor patient outcomes and drive improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that when risks are identified that they are recorded, reviewed regularly and timely action is taken to mitigate them.
- Systems should be in place to ensure emergency equipment and medicines were safe and fit for purpose.
- Staff who have responsibility for assessing, planning, intervening and evaluating children's care, must be trained to level three in safeguarding.

Action the provider SHOULD take to improve

- The hospital should ensure that the work commenced following the inspection to ensure that theatre staff do not wear their theatre shoes outside the department and that their scrubs are covered, continues. This is in line with Association for Perioperative Practice guidelines.
- The hospital should continue the work commenced following the inspection, to ensure that the operating department is not used as a thoroughfare for members of staff.
- The hospital should ensure that all staff present within the operating theatre are recorded.
- The hospital should ensure that the principle behind taking time out before commencing surgery is fully practiced with all staff present and participating.
- The hospital should develop a local protocol for the management of changes to operating lists as specified in the hospitals operational policy for operating theatres.
- Learning from complaints, audits and incidents should be reviewed and information about learning shared within a communication system with staff.
- Staff need to be supplied with training to build knowledge and confidence of consent processes, mental capacity act and deprivation of liberty safeguards.
- Locally devised clinical audits should be considered to monitor service improvements.
- The hospital should monitor patient waiting times in response to patient feedback received, to try and improve patient experience.
- The hospital should ensure that hard copies of histology and cytology results are kept in a secure area, not consultants post trays, in order to protect patients' confidential information.
- The hospital should ensure that there is a system in place to keep emergency contacts details up to date.
- The hospital should ensure that there is an annual major incident scenario is undertaken, in line with Ramsay policy.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Risks were not always identified, monitored and mitigated in a timely manner. Department managers did not check systems to ensure emergency equipment and medicines were safe and fit for purpose