Care Quality Commission

Winfield Hospital

Quality Report

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Date of inspection visit: 27 February 2018
Date of publication: 30/05/2018

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

Winfield Hospital is operated by Ramsay Health Care UK. The hospital provides surgery for adults, outpatient care and diagnostic imaging.

We completed a comprehensive inspection in August 2016 as part of our national programme to inspect and rate all independent hospitals. We returned to the hospital on 27 February 2018 when we conducted a focused inspection on surgical services. This was an unannounced inspection (they did not know we were coming) which enabled us to observe routine activity. We did not inspect outpatients and diagnostic imaging on this occasion. We carried out this focused inspection to follow-up on the areas that had been identified as requiring improvement at the last inspection and in response to concerns raised with us about surgical services and intelligence we hold through ongoing monitoring.

We asked two questions of the service during this focused inspection: are they safe and are they well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

We found the following areas of good practice:

Summary of findings

- The service had a good reporting culture and learned from things that went wrong, they reported and investigated incidents and made recommendations for improvements.
- There were good infection control procedures. Staff and premises were clean and regular checks ensured standards were maintained.
- Medicines were managed in a way to ensure patients were safe. They were stored securely, controlled drug records were regularly audited and charts were checked daily to ensure medicines were correctly administered.
- There were effective safeguarding processes helping to protect people from abuse.
- There was a well-defined strategy and vision for the service prioritising high quality care. There was also a well-embedded set of organisational values so staff knew what was expected.
- There was a comprehensive audit programme to ensure quality was routinely monitored.
- Managers had the skills and experience to lead effectively; there was a desire to continuously improve and there was a respectful culture between managers and staff.
- The hospital sought feedback from patients and staff to learn how they could improve the service. We saw staff were consulted over changes and had the opportunity to contribute when things affected them.

We found areas of practice that required improvement in services:

- The way the hospital applied duty of candour did not meet the regulatory requirements. Where the relevant person had not been notified in line with the regulatory requirements for specific reasons, there was no audit trail that explained why this was the case. The hospital did not always provide an apology and some records were not held in a place where they were accessible.
- There was no evidence that the hospital had monitored actions following serious incident investigations to ensure improvements had been completed.
- The audit programme was not always delivered in line with the company's expectations. Some audits had been missed and it was not always clear what action was going to be taken, by whom and when it was due to be completed.
- Risk registers were not used effectively to monitor and escalate risks. The hospital had not been following the company's processes to manage risk, although they had started to address this.
- Compliance with mandatory training was poor in some subjects, particularly for face to face training.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Standford

Deputy Chief Inspector of Hospitals, on behalf of the Chief inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		Surgery was the main activity of the hospital. We did not rate this service because we conducted a focused inspection on only two key areas. We did not collect sufficient evidence for us to give an overall rating for this core service.

Summary of findings

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Summary of this inspection

Background to Winfield Hospital

Winfield Hospital is part of the Ramsay Healthcare Care UK and provided surgery and outpatient services for NHS, self-funding and private patients. The hospital was situated on the outskirts of the city of Gloucester and the majority of patients lived in the city and local area.

The hospital had 39 beds and three operating theatres. There were also 11 consulting rooms, two treatment rooms, a physiotherapy suite and radiology facilities. They specialised in spinal and orthopaedic surgery, but provided a range of surgical services including general surgery, ophthalmology, urology, gynaecology, cosmetic, bariatric, maxilla-facial, and dermatology. The hospital was also JAG (joint advisory group for gastrointestinal endoscopy) accredited for the provision of endoscopy services.

The hospital's Registered Manager, Kathie Rimmer, has been in post for approximately two years. There was a new clinical manager/matron who had been in post for four months. The Registered Manager was also the controlled drug Accountable Officer.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, one other CQC inspector, and two specialist advisors with expertise in operating theatres and governance. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

We spoke with 15 staff including; registered nurses, health care assistants, operating department practitioners, an engineer, pharmacy staff, department managers, and administrative staff, medical staff, and senior managers. We also reviewed four sets of patient records.

Information about Winfield Hospital

We last conducted a comprehensive inspection at this hospital in August 2016. On that occasion we inspected surgery, outpatients and diagnostic imaging and gave it an overall rating of requires improvement. At that time we looked at five key questions and gave them the following ratings:

- Safe required improvement
- Effective was good
- Caring was good
- Responsive required improvement
- Well led required improvement

We gave the hospital these ratings because we found a number of areas where the regulatory requirements were not being met. We issued two requirement notices and requested an action plan detailing how they would address the risks. We re-visited the hospital and carried out an unannounced focused inspection on 27 February 2018 when we looked at surgical services. We focused our inspection on whether surgical services were safe and whether they were well-led. We particularly considered the progress made towards the requirement notices issued following our inspection in 2016.

The hospital is registered to provide the following services:

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

The hospital provided elective surgery to NHS and private patients, including insured and self-funding patients. They did not provide treatment to children. Patients could be treated as a day-case, or as an in-patient. During our inspection, we visited the theatres, recovery areas and the ward. We also inspected the radiology and physiotherapy suites where they related to surgical services.

Summary of this inspection

The physiotherapy suite was used for in-patients needing post-operative rehabilitation. It included an equipped gymnasium and an anti-gravity treadmill for patients who have had lower-limb surgery. The radiology suite included pre and post-operative diagnostic scans including fluoroscopy, ultrasound, radiology, x-ray, MRI and CT services.

Winfield Hospital also ran out-patient consultant-led clinics and radiology and physiotherapy services which were not included on this inspection.

In total, 148 Consultant Surgeons and nine medical staff worked at the hospital under a 'practising privileges' arrangement. They were supported by medical and surgical staff, including anaesthetic services. These were mostly provided through an agency. The hospital also employed five pharmacy staff, four radiographers, seven physiotherapists, 53 nursing staff, 10 sterile services technicians and nine operating theatre staff. There were also a range of managerial and administrative staff and those working in support services, such as catering, portering, housekeeping and maintenance. Of the 240 employed staff, 80 worked on a bank contract.

In the reporting period 1 February 2017 to 31 January 2018, 5,726 patients were admitted to the hospital on an inpatient and day case basis. 47% (965) patients were private and 53% (1,730) were NHS patients. The most common procedures related to general surgery (including endoscopy), ophthalmology and orthopaedic surgery.

Track record on safety – in the last 12 months:

- Zero Never events
- Seven Serious incidents
- 10 complaints

Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)

Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Zero incidences of hospital acquired Clostridium difficile (c.diff)

Zero incidences of hospital acquired E-Coli

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department
- Joint Advisory Group on GI endoscopy (JAG) accreditation (renewed February 2018)
- ISO/IEC 27001:2013 Patient information security management system (renewed April 2016)

Services provided at the hospital under service level agreement:

- Sterilising services
- High dependency beds
- Loan Equipment
- Resident Medical Officer (RMO) provision
- Radiology Services (MRI and CT scanning)
- Infection prevention and Control support
- Microbiology support
- Resuscitation Training
- Specialist pharmacy support
- Laboratory Services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as requires improvement because:

The documentation we reviewed to understand how the hospital delivered duty of candour did not demonstrate that they were meeting the regulatory requirements. This was a concern at the previous inspection and, although improvements had been made to this process, some elements still did not meet the regulatory requirements.

Where actions were identified following investigation of incidents, these were not being monitored consistently and senior managers did not always receive assurance that actions had been completed.

Staff attendance at face to face mandatory training modules was poor. Out of 19 modules, staff compliance had reached the hospital target in only five of the modules for theatre staff and six of the modules for ward staff.

However:

The service ensured staff were able to report incidents and investigations took place in order to learn and improve services.

The hospital monitored and compared its results with other hospitals in the Ramsay Group using the information to identify areas where practice needed to be improved.

Hygiene and infection control was a priority for the service and staff compliance with hospital policies was monitored. Investigations were undertaken if a higher number of patient infections were found.

Premises and equipment were suitable for their intended purpose. They were monitored for any risk and maintenance actions were taken to ensure equipment was safe for patient use.

Medicines, medical gases and contrast media were managed safely at the correct temperatures. Stocks were regularly checked. Staff used a systematic approach to highlight when medicine expiry dates were due and audit processes ensured that safe standards were maintained.

Record keeping processes helped to keep patients safe. A full patient record was available for staff to use and was kept up to date. Quality of records was audited by the hospital and, where errors were reported; improvements were identified and shared with staff.

Summary of this inspection

Safeguarding processes were followed by staff to keep patients free from abuse. Policies supported staff in their actions and advice was available from staff with additional skills in safeguarding.

Staff told us there had been an increase in staffing numbers over the previous 12 months and although they were busy staff felt their caseloads were manageable. Temporary staff were used less than 25% of the time and induction processes supported them to familiarise themselves with their area of work.

The hospital reviewed qualifications of medical staff and only allowed consultants to work in the hospital once the standards had been met. Registered medical officers were supplied by a medical agency and cared for patients' day to day needs. Their agency supported RMOs if any concerns were raised by hospital staff.

Are services effective?

This was a focused inspection which did not include this question.

Are services caring?

This was a focused inspection which did not include this question.

Are services responsive?

This was a focused inspection which did not include this question.

Are services well-led?

We rated well-led as requires improvement because:

Although we saw that many audits had been completed, we found that some key audits had been missed and there were some occasions when poor compliance had been identified, but there was no clear improvement actions, no person responsible for the improvement and no timescale for completion.

Risk registers were not used effectively to monitor and escalate risks. There was limited discussion and oversight of new risks in relevant committees and risk assessments were not always completed in line with the company's process.

There was sometimes poor monitoring of actions from governance processes. Staff reporting risks and incidents did not always receive feedback, there was no system for monitoring to ensure actions from serious incident investigations were completed and audits did not always identify specific actions and identify who would be responsible for improvements and when they should be completed.

However:

Summary of this inspection

There was a well-defined vision and strategy for the hospital and for surgical services. Senior managers had set their key priorities and understood where they needed to improve to meet the hospital's business and clinical goals.

There was an effective governance structure with clear lines of accountability. Staff, department leads and managers understood their roles in relation to quality and there was a collective sense of responsibility for providing high quality care.

There was a comprehensive audit programme and outcomes were reviewed to identify where improvements were needed. Issues were addressed and actions were discussed with the departmental teams.

There was an open culture where information about quality was shared with staff, patients and local stakeholders.

Although there were historic problems with the leadership in theatres during the previous 12 months, there was now effective leadership in theatres and on the ward with the necessary skills and experience lead services.

There was an open and respectful culture amongst staff and managers, and across the disciplines. Staff were comfortable challenging each other and relationships were positive and supportive.

The hospital had improved how it engaged with staff. Meetings that had been infrequent or had stopped had re-commenced. Staff views were sought; they received information to help them in their role and staff said they felt consulted about changes affecting them.

The hospital sought feedback from patients and used their views to shape services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	N/A	N/A	N/A	Requires improvement	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Surgery

Safe	Requires improvement
Well-led	Requires improvement

Are surgery services safe?

Requires improvement

We rated safe as **requires improvement.**

Incidents

- The service reported and investigated patient safety incidents well and identified actions that would reduce the risk of incidents recurring. Action plans were widely shared and discussed, although completion was not monitored to provide assurance actions had been completed.
- Between 1 February 2017 to 31 January 2018, seven serious incidents were reported for the hospital. None of these were classified as never events. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Staff investigated these incidents initially and followed with a more detailed investigation if it was appropriate. At our last inspection we found that insufficient staff had been trained how to undertake systematic investigation of incidents called root cause analysis. At this inspection we found that this had been addressed and senior staff had received training in root cause analysis. This process is aimed at identifying what happened and what could be changed to reduce risks in the future. Information from these investigations was shared using a range of methods including clinical governance, heads of department and departmental meetings.
- Staff recognised incidents and reported them using the electronic reporting system. Managers investigated these incidents and shared lessons learned with their teams and with senior managers. Minutes of these meetings recorded some discussion on the recommended actions. However, there was not always a record of completion dates of these or how they would be monitored in the future. We were not able to track all actions through as having been completed.
- Feedback on reported incidents was not given. Learning from incidents was discussed at department team meetings but some staff had not received feedback from incidents they had reported. One example of this involved the sterilising department who ensured the used surgical trays had the correct number of items returned. Any additional items on the trays, such as scalpel blades, were reported as an incident. Records showed by February 2018 there had been no feedback received for issues reported in December 2017. However, we saw departments had documented discussions about these additional items on surgical trays.
- Senior managers had oversight of reported incidents and graded them according to severity. Some high-risk incidents were added to the hospital risk register if no immediate solution was available, but this had only started to happen recently and was not consistently done. The hospital kept a log of reported incidents and any actions taken to resolve issues, although one staff member told us that they had not received feedback about actions taken in response to some of the incidents they had reported. Between the period 1 February 2017 to 31 January 2018, 256 incidents had been reported. These included incidents such as injury to staff, patient falls, and incorrect information sent to patients and incorrect labelling of specimens. Incidents were graded for their level of severity and investigations took place to identify where risk could be reduced. Learning was shared with staff at meetings and using the hospital 'bite size' newsletter.
- Staff had access to the hospital risk register but some had difficulty finding the incident they reported which meant they could not see the action taken by the hospital to address the concern. Senior managers recognised these difficulties and were in the process of

changing the system they were using for staff to report incidents. The new system was intended to make it easier for staff to review any feedback relating to reported incidents.

- Duty of candour was not always fully applied in line with the regulatory requirements. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in April 2015 for independent providers. The Regulation requires the hospital to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support in relation to the incident, and offer an apology. This should be done in person and as soon as is reasonably practicable after becoming aware that a notifiable safety incident has occurred.
- In the 12 months prior to the inspection, there had been three cases where duty of candour principles had been applied. We looked at how the hospital had applied duty of candour. Two of the cases documented that a conversation had taken place with the patient, however the records of initial conversations and notification letters could not be accessed during the inspection. After the inspection the hospital manager was able to provide this information. One case recorded that duty of candour letters were sent by the general manager of the hospital, rather than a face to face conversation. We reviewed this case in full. The regulation requires that the relevant person is informed in person as soon as possible after the incident has occurred. On this occasion they had been informed in writing 24 days after staff had become aware and there was no explanation for the method or timing of the contact within the duty of candour record. After the inspection the hospital was able to provide the reason they notified the family by letter and the reason for the delay, however there was no audit trail of these reasons within the hospital's records. When we raised this with the hospital, they told us that they plan to keep a more detailed record of duty of candour going forward. The hospital had updated the family at the end of the investigation in writing and outlined where improvements had been made to the service, however no apology had been given.
- The hospital provided no training about the duty of candour regulations but operated a Ramsay group policy of “Being Open”. This policy gave detail about what staff responsibilities were if a mistake occurred or if a patient experienced some degree of harm. Additional guidance regarding staff and organisational obligations around the duty of candour had been circulated for staff to read. Not all staff had heard of the duty of candour regulation but described how they would be open and honest with patients. This included giving patients information of any difficulties there had been during their surgery and of any delays to their planned care.

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

- The service collected safety monitoring results so their safety performance could be compared with other providers. Monitoring information was collected and compared with results from other hospitals within the Ramsay Group. Managers used this information to assess how well they were performing within the Ramsay Group. Staff collected safety information and contributed to the NHS safety thermometer monthly. This information was publically available on the Health and Social Care information website. It could be used to identify trends of patients suffering pressure ulcers, falls, venous thromboembolism (blood clots) and urine infections (for patients with a urinary catheter). Senior managers could access this site but information from it was not analysed or displayed on the ward. However, reports showed between February 2017 and January 2018, 100% of patients had received harm free care.

Cleanliness, infection control and hygiene

- The hospital managed infection control and hygiene well. They monitored infections and cleanliness of equipment using a variety of audits and ensured staff followed their policies. Incidence of infection was reported to the Ramsay organisation and results were compared with other hospitals within the group. Where there were increased infection rates, investigations were undertaken to identify actions that might improve the situation.
- The hospital monitored the risks of patients acquiring infections and reduced the risk by screening patients for infections such as MRSA, before they were admitted to the hospital. In the period between 1 February 2017 to 31 January 2018 there were no incidences of MRSA, MSSA, C-Diff or E Coli. The infection control lead for the hospital attended clinical governance and heads of department meetings to discuss actions needed and

share learning. Meeting notes recorded recommended actions to ensure good hygiene was maintained and this was followed up at the next planned meeting until the action was completed.

- A new lead nurse for infection control had been appointed within the hospital. Since this appointment, incidence of infection had increased from zero (July to September 2017) to four infections (October to December 2017). The increase in the infection rate was attributed to improved reporting procedures. This was because some wound infections had been mislabelled as wound integrity. The hospital had changed this practice to ensure that all infections were identified and properly investigated. investigated as infections. The rate of infections for this quarter was 1% and the Ramsay group target was for infection incidence below 1%. An investigation was undertaken to identify any learning points based on these results and was ongoing at the time of our visit.
- Patients who developed an infection could be isolated from others. Most patient rooms were individual with private bathroom facilities. Personal protective equipment such as aprons and gloves was readily available for staff to use. Dispensers of sanitiser gel were available for staff, patients and visitors to use on entry and exit to ward areas and patient rooms.
- Surgical instruments including flexible endoscopes were decontaminated after each use, within the hospital site by the sterilising department. The process followed national guidance from the Health Technical Memorandum on decontamination. Air ventilation systems were in theatres to reduce the risk of airborne contaminants. Theatres, endoscopy and theatre sterile services unit (TSSU) areas were deep cleaned every six months.
- Staff training on infection control was provided within the hospital and hand hygiene audits were undertaken regularly to monitor compliance with protocols. Staff were informed immediately if there were areas they needed to improve. The hospital undertook monthly observational audits of staff cleaning their hands before and after contact with patients. This identified 100% compliance between October 2017 and January 2018. A more detailed observational audit happened every six months. This included length of fingernails, jewellery worn, and hand cleansing method used. Some areas identified for action included nail varnish and rings with stones in being worn, and was fed back to staff. All staff we observed followed the hospital policy of being bare below the elbow and cleaned their hands between patient contact.
- Staff followed hospital policy when preparing for invasive surgery in the theatre suite by cleansing hands from fingers to elbow and wearing sterilised gowns and gloves before having contact with the patient. Patient skin was cleansed using recommended solutions.
- All areas we visited appeared visibly clean and most had surfaces that could be easily decontaminated. A refurbishment programme was being undertaken to remove carpets from clinical areas. This had been completed in all patient rooms except three, which were due for completion the week following our visit.
- The Patient Led Assessment of the Care Environment (PLACE) scored by the hospital for cleanliness was 99.4% for the year 2017. PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). This score was an improvement on the previous year's score of 89% and was above the national average of 98.4%
- The housekeeping team completed monthly audits to assess cleanliness of surgical areas and equipment. A record of findings identified action points to ensure areas were kept clean and dust free. This included general cleaning of floors, sinks, taps and areas high up or low down which were difficult to view. Equipment used for general cleaning was readily available and a system of allocating this equipment to individual areas prevented cross contamination.

Environment and equipment

- Premises and equipment were suitable for their purpose. The hospital inspected equipment regularly to ensure it was maintained and safe for use. Equipment near the end of its lifespan was identified and we were given examples where discussions and planning for replacing the item had commenced. Areas were being updated gradually in order to maintain a safe patient environment. This included facilities to store equipment and medicines, inpatient rooms, physiotherapy areas and equipment used by surgical services.

- The monthly housekeeping audit included the maintenance of facilities including the level of lime scale on taps and condition of tile grout. Maintenance staff dealt with any issues identified and these were checked at the next audit.
- Staff reported equipment breakdowns as incidents and placed them on the hospital risk register where appropriate. The sterilising department had reported a breakdown of a sterilising unit. A management plan was in place and a replacement unit was being discussed with the corporate Ramsay group. This was because they were reviewing their processes of decontaminating equipment within their hospitals. The incident remained on the hospital risk register to monitor safety.
- Resuscitation equipment was available in surgical areas for staff to access in an emergency. Trolleys were fitted with tamper evident tags, which were logged as checked daily. Staff completed a more detailed check of the equipment each week to ensure equipment was in good order and medicines were within their use by date.
- Staff followed processes which met with national guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). This included checking equipment and ventilators were safe to use before being used on patients, and hoses were intact, properly attached and working.
- Staff used systems to ensure equipment was safe for use during surgical procedures. Surgical equipment was checked and systems tracked each stage of decontamination.
- Processes for lifting and moving patients and equipment protected staff and patients from harm when lifting and moving patients. Manual handling training was mandatory for all staff and equipment was available to move patients whose high body weight would cause difficulties for staff.
- The hospital had two generators, which would be used to provide electrical power if there was a sudden power outage from the mains supply.

Medicines

- Medicines, medical gases and contrast media (used for certain procedures) were managed safely. Staff followed national guidelines when storing and administering medicines. Controlled medicines, such as strong painkillers like morphine, were stored securely. Stocks were checked and signed at the start of each day by two staff members.
- All medicines were stored safely away from public access and were accessible to staff using keys. The radiography department had installed a locked cabinet in which to store contrast media. This was accessed by staff using a key, which was kept in a number coded cabinet.
- We saw medicines being stored in temperature controlled environments including emergency trolleys. At our last inspection found that some medicines used in imaging were stored above the recommended temperature. At this inspection we found that staff recorded daily checks of temperature gauges and followed the hospital standard operating procedure to report temperatures outside of set parameters. This included refrigerated medicines.
- The hospital pharmacy undertook monthly audits of medicine stocks including controlled drugs. This looks at areas such as the completion and checking of patient medicine records on admission and the administration of prescribed medicines during the patient's inpatient stay. Issues had been identified through audit, such as the checking of medical record within 24 hours of admission for those patients admitted on a Friday due to the weekend closure of pharmacy. Actions were identified to address this and ensure that charts were checked on the day of admission.
- Systems had been introduced to decrease the risk of error in medicine administration. They were taking steps to decrease medicine errors and unnecessary wastage by reducing stock kept in ward areas. Pharmacy staff used a 'red dot' system where a red sticker was placed on medicine containers when they were close to their expiry date. Pharmacy staff checked patient medicine charts for any discrepancy and signed each prescribed item. Any errors were highlighted to the prescriber.

Records

- Patient's had individual care records and risks assessments recorded in a way that prevented harm. The overall record was kept securely in an area away from patient and public access.
- Staff could access a continuous record for each patient, which documented their medical history and planned treatment. All staff caring for the patient in the hospital contributed to this patient record. Notes were divided into sections for ease of review and summary of care

delivered and patient responses were recorded. The four patient records we reviewed were legible and completed appropriately with each entry signed by the staff member.

- Care records in progress were kept with the patient. These were records used by nursing staff to record immediate care delivered and condition of the patient. For example, management of pain, fluid intake and output, heart rate, blood pressure and respiration rate.
- Since our last inspection the surgical service had developed pathways of care for patients who were assessed as having an additional health risk. This helped staff to document management plans for these patients such as a person with diabetes, management of patients at risk of acute kidney failure and management of patients with a urinary catheter in place. The pathways were based on national guidance for each risk or condition and communicated to staff how they should care for the patient.
- The hospital carried out audit of records for quality and completeness. Issues identified were shared at clinical governance meetings and fed to staff using team meetings and individually when appropriate. Targets of compliance for this audit were divided into colours to indicate their level of concern.
  - Green – 100% compliance
  - Cool Amber – 90-99% compliance
  - Amber – 80-89% compliance
  - Hot amber - 70-79% compliance
  - Red – 79% and below
- Of the 30 patient records audited, 86% met the Ramsay Group record keeping standards and was labelled as amber. Some issues had included incomplete surgical records before the patient left theatre and ensuring all patient fluid balance charts were up to date and there were accurate records of patients' vital signs on early warning score charts. Heads of department were provided with results of the audit so they could share with staff and encourage improvement.

Safeguarding

- Safeguarding arrangements in the surgical service followed national guidelines. Winfield Hospital staff could access a lead nurse for safeguarding adults and children. These leads were senior staff who had completed additional training in safeguarding adults and children procedures to level three. Ramsay group had a lead for safeguarding adults and children if further support was needed. We were given a recent example of an incident where a new member of staff had successfully followed the pathways available and reached a positive outcome.
- Training for safeguarding adults and children was mandatory for staff to complete and provided in e learning modules as well as face to face modules. Attendance levels did not always meet the hospital compliance target of 85%. This was mainly in the face to face training modules. The hospital did not accept children under the age of 18 years for surgical procedures but staff were expected to complete level two safeguarding training for children.
- Face to face modules, one for adult safeguarding and one for child protection, needed to be repeated at three yearly intervals. Records showed for face to face modules, only 30% of ward staff and 31% of theatre staff had attended child protection training and 51% of ward staff and 31% of theatre staff had attended adult safeguarding training. We were provided with training figures after our visit and were not provided with any action plan to improve the low attendance figures.
- Six e learning modules were provided in addition to the face to face modules and are listed below:
  - Safeguarding Adults - Level 1
  - Safeguarding Adults - Level 1 Assessment
  - Safeguarding Adults - Level 2 (Includes DoLS and Prevent)
  - Safeguarding Adults - Level 2 Assessment
  - Safeguarding Children - Level 1 - Introduction to Safeguarding
  - Safeguarding Children - Level 2 Part C - Record in Secondary Care
- Deprivation of Liberty Safeguards (DoLS) is designed to protect a patient's rights if they need to be detained in hospital and they lack the mental capacity to make decisions. Prevent training is introductory training around recognising supporting those at risk of radicalisation and becoming a terrorist. There were two modules for safeguarding adults level two. One which included DoLS and Prevent training and one level two assessment. The hospital provided rates of staff attendance at these e learning modules for the hospital as a whole and we had no way of identifying attendance rates of staff from the surgical unit. Overall attendance at e learning modules met the hospital target in five of the modules and the remaining module (safeguarding children level two part C) was reported as just below at

81%. Staff compliance rates provided did not add up correctly in one module - safeguarding adults level two (including DoLS and Prevent). This was when the attendance rate was further broken down into substantive and bank staff attendance. The hospital reported overall attendance as 100%. However, there had been 0% attendance for substantive staff and 100% attendance of bank staff.
- Staff we spoke with were able to describe what concerns they might report and who they would go to for support. One staff member described how they found the hospital safeguarding policy supported them in reporting and managing concerns about a patient who was at risk of being abused. This had resulted in a plan of action involving wider health services outside of the Ramsay organisation.

Mandatory training

- The service provided mandatory training in key skills to all staff and monitored staff attendance. However, we could not be assured staff were fully up to date with skills that would maintain patient safety. Training was delivered face to face and using e learning programmes. Subjects included manual handling, basic life support, health and safety, emergency management and fire safety. Senior managers monitored staff attendance at mandatory training but attendance rates showed many staff had not attended face to face modules. Out of 19 modules, records indicated that attendance targets for ward staff had been reached in only six. For theatre staff attendance targets had been met in only five of the modules.

Face to face training was divided into departments. The lowest attendance rates were:

- 3% theatre nursing staff for ANTT (Aseptic no touch technique). The registered manager advised that training sessions were due to take place soon.
- 9% theatre staff attending WHO (World Health Organisation checklist) training, although the registered manager advised that this training was not currently available.
- 14% ward staff attending basic life support training. The registered said that this figure did not accurately reflect the proportion of staff who required this training as most would complete the intermediate course.
- 46% ward staff and 23% theatre staff had attended Intermediate life support training.

The best attendance rates for face to face training were:

- 100% ward staff had attended modules titled 'manual handling, non-clinical staff'' 'basic life support – non clinical staff' and 'care certificate for health care assistants and physiotherapists'.
- 91% of theatre staff had attended training titled 'the care certificate for health care assistants and physiotherapists'.
- 86% of theatre staff had attended 'manual handling', 'fire extinguisher' and 'basic life support for non-clinical staff'
- 86% of ward staff had attended 'blood transfusion competency', 'fire extinguisher'.

- Heads of departments meetings discussed training planned and dates that staff could attend. The February 2018 meeting identified intermediate life support training sessions were fully booked and additional weekend dates had been arranged for advanced life support training with priority given to Winfield Hospital staff. Additional training was planned over the next few months in several of the subjects.
- Compliance for e learning modules for theatre department and the ward included substantive staff and bank staff attendance. The ward staff attendance rate was 95% and theatre department attendance was 83%, just below the hospital's 85% target.

- Staff were able to access an electronic copy of training they had completed and when it was next due. We were shown electronic records of individual staff training. This showed modules completed and those which were overdue for updating. Staff had not been aware of the overdue modules. No electronic reminder had been received to prompt staff to attend although managers reminded staff to check their training records and keep training up to date. Senior managers informed us a new system was being installed that would send reminders to staff when training was due to be updated and this would improve attendance at mandatory training modules. There were regular discussions about mandatory training in governance meetings and heads of department had been asked to make completion of the training a priority.

- Sepsis training was introduced for staff to attend since 2017 and we were told 17 out of 53 nursing staff from the hospital had attended and remaining staff were booked on to planned sessions. The objective was for all

clinical nursing staff and health care assistants to have attended this training programme by the end of 2018. Additional information about how staff recognised a signs of sepsis in a patient and what to do if these signs were present were displayed in nursing areas for staff to view.

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

- Staff used tools to assess record and guide their practice regarding clinical risks to patients. These were produced by the hospital and based on national guidance. Patients undergoing major surgery had an outpatient appointment to assess their condition preoperatively. Telephone consultation contact with patients undergoing minor surgery was documented on an assessment form to monitor potential risks to the patient. The assessment was thorough and included previous medical history, how existing conditions were managed by the patient, mobility and any issues affecting their wellbeing. Staff used these assessments to decide whether their condition met the hospital criteria for admission and could be safely treated at this hospital. Patients with additional conditions such as diabetes or who were at risk of developing acute kidney injury were subject to additional assessments. Pathways of care provided guidance for staff on actions they needed to take and additional monitoring of the patient condition.
- Staff followed hospital policies in their management of deteriorating patients. Staff documented patients' conditions using a National Early Warning Score (NEWS). This chart was completed by nursing staff and gave guidelines for actions needed if a patient's condition deteriorated. It included records of oxygen saturation, blood pressure, temperature, heart rate and blood sugar. A score was generated according to set parameters and actions were advised depending upon the score. This included using the sepsis screening tool and informing the Registered Medical Officer (RMO) for the hospital. All NEWS records we saw were completed appropriately although none had needed to be escalated to the RMO at the time we visited.
- Training scenarios took place to maintain staff skills in managing urgent situations. This included resuscitation of a patient and managing cases of life threatening haemorrhage. Senior staff assessed where staff needed further support and repeated the training scenario. This gave staff the opportunity to practise their skills without harming patients and learn how to improve. We saw meeting minutes, which recorded how staff had managed a second resuscitation scenario more successfully than the first.
- Patients who needed further specialist or critical care services were transferred to the local NHS acute hospital. The Winfield Hospital had a contractual agreement with the local NHS acute hospital regarding transfer of these patients. In the year prior to the inspection there had been five unplanned transfers of patients for higher acuity care.
- Risks to patient safety were reduced with the use of the nationally used 'five steps to safer surgery'. This was a World Health Organisation surgical safety checklist which encouraged team work and communication within the surgical team to reduce errors. We saw how each team member took responsibility for their actions, checked the patient's identity, talked to each other and ensured they had the correct patient for the correct procedure before starting the surgery. Compliance with completing these check lists was monitored monthly using a review of the paperwork to ensure the checklists had been completed. Monthly observational audits of the WHO checklist had also been completed. This audit showed staff compliance levels but we did not see a list of identified actions with the purpose of improving areas of concern. Between July and November 2017 staff compliance with the process was reported overall as 95%. Activities around the debrief for theatre staff had been identified as a concern in the September 2017 audit and in the October and November 2017 all staff were shown as compliant. We saw no record of whether this improvement resulted from an action plan after the audit and therefore if improvement was likely to be sustained.
- Staff followed the hospital policy on assessing and treating risk of patients developing venous thromboembolism (VTE). The policy was, however, beyond its review date of September 2017. It contained advice for staff on the most appropriate methods of preventing VTE for their patients but the responsibility prescribing treatment remained with the patient's consultant. We reviewed four patient records and each had detail of VTE risk assessment and treatment prescribed.

- Patients were provided with contact details if they needed further support for their condition after discharge from the hospital. Nursing staff told us they were able to gain advice from consultants if they needed further advice.

Nursing and support staffing

- The service had enough staff with the right qualifications, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, staff were at risk of not providing the most up to date care because not all staff had attended mandatory training refresher and update courses.
- Staffing was organised for the surgical areas using a national acuity tool. This used the number of patients to assess how many staff were needed to care for them. Staffing was reviewed each week against the planned intake of patients the following week and rearranged according to the acuity of the patients based on risks and medical history. The ward manager used her professional judgement to reassess the planned nursing staff numbers and allocated more staff if she felt this was needed. The new theatre manager had recently questioned the interpretation of the tool and was discussing a need to increase staffing numbers in theatres. This discussion was ongoing at the time of the inspection.
- Staff told us there had been an increase in staffing numbers over the previous 12 months. Any shifts short of permanent staff were filled with bank or agency staff. The hospital had bank of staff who were familiar with the hospital and if they were unavailable an alternative agency was used to provide staff. Staff told us this was not needed every day and permanent staff were always on duty at the same time to ensure bank or agency staff were supported. Any bank or agency staff who were new to the hospital received an induction of the area in which they were working. Staffing records showed between March 2017 and January 2018 the ward area used no agency staff and a small number of shifts were filled by bank staff. This ranged from 1% and 5% of bank staff usage for each month. Theatre department used bank and agency staff to a slightly higher level. For the same time period bank usage ranged from 2% to 12% of shifts each month and agency usage was between 8% and 17% of shifts each month.
- Nursing staff carried out comprehensive handovers of patients between shifts. These handovers were between nursing staff only. Nurses gave an overview of patient care provided and what any patient's ongoing needs were. All staff were attentive and able to ask questions if they needed further clarity.

Medical staffing

- Medical staffing was adequate to meet the needs of the patients in the surgical unit. Surgical consultants led the care of their patients and anaesthetists were available for pre and post-operative care. Consultants could attend the hospital within 30 minutes for urgent situations. Nursing staff and the registered medical officer (RMO) told us there were no problems in accessing support from surgeons if they needed it.
- Registered Medical Officers (RMO) covered the day to day patient needs for seven days at a time. These doctors were supplied from a pool of staff provided by an agency. The agency provided additional staff if, for example, medical staff were working long days and had been engaged with patients' clinical needs during the night. Senior managers reviewed competency of RMOs who were allocated to the hospital before they commenced their shifts. It was the responsibility of the agency to provide supervision for staff when staff raised concerns about their practise. Managers told us of occasions they had expressed concerns and the agency had provided additional support for the RMO.
- Consultants provided RMOs with handover information following surgery and any specific actions the RMO needed to take to provide effective patient care. The consultant informed nursing staff of specific actions following a patient's surgery and nursing staff cascaded this to their colleagues.

Emergency awareness and training

- The service planned for emergencies and staff understood their roles if one should happen.
- Fire evacuation tests and evacuation plans were discussed at hospital meetings regarding health and safety. The Ramsay Group policy was discussed at senior hospital meetings where an action to make the policy relevant to the hospital level was identified. Fire officers within the hospital had responsibilities in the event of fire or major incident. They were provided additional equipment such as mobile communication

devices that did not rely on telephone signals. Fire practice drills were undertaken and reviewed for learning and improvement of the processes. Staff stated the process had improved following practice sessions.

Are surgery services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership of service

- There was an appropriate framework of leadership supporting surgical services. There had been some recent senior management changes in the hospital. This included the clinical manager and the theatre manager. The theatre suite had been without a permanent manager for over 12 months. New managers had been recruited in September-October 2017, so were relatively new at the time of the inspection. Both appeared to have the skill, experience and knowledge required to lead effectively. Staff we spoke with had found the management change had been positive and could identify improvements in the way services were provided.
- The surgical service was divided into departments. These included the theatre suite, the sterilising unit and the ward area. Each department had a separate manager. Staff knew who their managers were and felt comfortable in raising any concerns when they needed to. The theatre manager was new to the hospital and had been in post for three months. Ward, theatre and decontamination managers reported to the clinical manager of the hospital. Managers met once a week to discuss plans for the following week including staffing, equipment and any special requirements. A new post of deputy theatre manager had recently been confirmed but had not been filled at the time of the inspection.
- The priorities for managers leading theatres had been clearly communicated and a high level of improvement activity had occurred since their arrival. For example a new planning meeting had been introduced to enable better planning of resources and equipment. Both managers were clear about their plans and priorities for the coming months. We found many of the improvements to theatres had been introduced recently, so the full benefits had not yet materialised.
- Managers were willing to take action to address individual performance issues, regardless of seniority. Most incidents were handled through discussion and learning, however some difficulties were experienced when handling embedded behaviours inconsistent with the hospital's values. We saw evidence of action taken to address such issues and further support was provided by the wider Ramsay organisation when they needed it.

Vision and strategy for this core service

- There was a clear objective-led strategy for the Ramsay group, which was quality-based. This was a five-year plan had been published in 2014. There was also a separate strategy for Winfield Hospital which looked at the areas of leadership, clinical governance, quality, people, growth opportunities, cost management, customer service and the environment. The strategy also described the kind of culture that it wanted to embed in its staff, such as a culture where people wanted to make a difference, and a culture where individuals are valued.
- The hospital had also developed a specific clinical strategy that had last been reviewed in November 2017. This had seven key elements including areas such as delivering high standards of care, treating patients with dignity and respect, staff act as the patient's advocate, ensuring staff feel valued and take pride in their departments. Guidance was provided to staff on how they could achieve those goals and we saw those values embedded in staff during our inspection.
- There were a defined set of Ramsay values applied across the corporate group. They promote 'The Ramsay Way' to staff with a list of beliefs and values that forms their business culture. The hospital also promoted the '6 C's' described by NHS England of care, compassion, competence, communication, courage and commitment.
- Staff understood the hospital and Ramsay vision and values and was aware of how they contributed to the patient experience. Staff we spoke with expressed their commitment to providing care that would make a positive patient experience for patients.
- The theatre manager who was new in post had been provided with the key priorities for surgery. These were supported by the clinical manager and the general

manager. The key priorities were focused on safety and were in line with the concerns raised within the last CQC inspection and the quality monitoring that had occurred since then.

Governance, risk management and quality measurement

- The corporate group had designed an effective framework of governance at the hospital to support the delivery of good quality care, although it was not always completely followed. Governance processes were reviewed regularly by the corporate group and we saw evidence of new tools and guidance to support senior managers.
- There was a comprehensive audit programme in place to ensure quality was measured within the hospital. We found most audits were completed and the results were discussed across the various committees. Audits included areas such as hand hygiene, record keeping, medicine reconciliation and observational audits in theatre. However, some operational audits had not been completed including ones relating to the ward and theatres, which meant that the hospital had not delivered the audit programme in line with the company's expectations. Where they had been completed, actions had been discussed in ward and theatre team meetings.
- An audit tool was used that collated audit results for the purposes of oversight and national benchmarking. Each department had a nominated person responsible for audits; however not all were using the computer-based tool. We were told by the registered manager that paper audits were used sometimes to allow staff to be involved in audit when it was not part of their usual role. The clinical manager told us that they intended to provide IT skills support so that they could use the computer-based tool.
- We saw evidence that many of the issues identified through audits had been followed up. In some instances there were clear actions from audits, such as from the hand hygiene and cleanliness audits. However, clear and specific actions following audits were not always identified. We saw some audits where there was low compliance in some areas, for example for theatre and outpatient audits, where actions, the person responsible and the date for completion had not been identified.
- Risk registers had historically not been used effectively to monitor and escalate risks, but the hospital had made recent improvements. We saw some recent examples of the appropriate recording of new risks and the steps taken to control and reduce the likelihood of harm. We were shown the existing hospital risk register, but there had been limited use of the risk register since the last inspection. No new risks had been added between May 2014 and November 2017. Two new risks had been added to the register in November 2017. We also reviewed the theatre risk register which included 16 new risks added in June 2017 but these had not all been reviewed at the relevant committee. We were told that a new system for recording and escalating risks was in the process of being introduced, which was likely to improve the process. We saw the use of the risk registers had increased since October 2017 with more frequent entries and correlation between the risks recorded and the incidents occurring hospital. We also reviewed one that had been escalated from a departmental register to the hospital register due to a high risk score. The risk had been discussed at the health and safety committee which gave assurance that the process was now working more effectively.
- Some task-based risk assessments had been completed and retained by the quality improvement lead, such as risk assessments for surgeons not using sharp-safe equipment. The assessments did not correlate with the new risks appearing on the risk registers as would be expected according to the organisational risk escalation process.
- There was limited monitoring of actions undertaken in response to serious incidents. Although the recommendations from investigations were widely shared and discussed at various governance committees, the hospital were unable to demonstrate how they ensured specific actions and recommendations had been completed. We reviewed a serious incident investigation where recommendations had been made to introduce a new standard operating procedure, improve a number of processes and re-issue existing instructions. There was no record of who had been nominated to complete the actions and no record of whether they had been completed.
- Since the last inspection, attendance at the Medical Advisory Committee (MAC) had improved and was now well-attended. There was a clear link between MAC and the hospital's clinical governance committee, with

updates on incidents and discussions about the learning identified. Appropriate discussions were taking place about new guidance, new procedures and proposed use of unlicensed drugs. Where this had not happened (one occasion had been identified during an audit), we saw this had been addressed.

- Information was routinely shared with the local clinical commissioning group, including infection rates, incidents, audit results and patient satisfaction survey results. These were shared at regular contract meetings.
- Learning from incidents was shared between other Ramsay hospitals in the region through a monthly matron's meeting.

Culture of service

- We saw staff of all levels treating each other with courtesy. Staff felt supported by their managers and described the hospital team as like a family. Managers recognised when individuals were undergoing extreme stress and ensured they were able to take time out if they needed it.
- There was an open culture that allowed staff to feel comfortable in challenging each other. This was to ensure they provided good quality care and encourage learning. Staff and managers spoke respectfully about each other. Managers were visible and approachable and we saw good working relationships. There was effective multi-disciplinary working in theatres, where each member was clear about their role and what was expected of them.
- We saw positive and supportive relationships between senior managers and departmental leads. They communicated frequently and effectively with each other. Managers we spoke with told us they were well-supported by their own line managers and by the corporate team. The new clinical manager had received support internally and met regularly with those in the same role in other hospitals in the corporate group.
- Managers told us the focus of the hospital at the time of we inspected was to achieve a culture of safety and quality. They were aiming for staff to go 'back to basics' and improve compliance with their protocols and procedures from which they could build.
- The Ramsay group had recently employed a new Chief Executive Officer (CEO). Managers at Winfield Hospital told us they had received a strong message that Ramsay culture was centred on quality. This was evident at the hospital and managers told us they were committed to providing good quality and safe care.
- The hospital was open with local stakeholders about their performance. Regular contract meetings took place between the hospital and the local CCG to discuss hospital performance and the care of NHS patients which comprised 50-55% of the hospital's work. The hospital said they also shared information about private patients for the purposes of quality monitoring.
- The hospital last produced a report on Work Race Equality Standard (WRES) data in December 2017. There was limited progress monitoring as it was the first year of collecting WRES data. The actions identified were organisational, rather than specific to Winfield Hospital.

Public and staff engagement

- The hospital engaged with employees in a variety of ways. The hospital conducted a staff survey every two years, asking questions about how they feel about matters such as their working environment, pay and recognition and their opportunities for development. Scores were benchmarked against a range of employers.
- The latest staff survey was conducted before the last inspection and we could see the actions identified from the last survey had been taken forward. Staff had previously commented they did not feel there was good sharing of information between managers and staff. In response the hospital had reformed the Employee Engagement Action Group, which was meeting on a monthly basis. They had also started to share the minutes from the morning manager's 'huddle' with the rest of the staff. Staff told us they found the information given to them from the daily huddle helpful.
- All levels of staff felt consulted about changes within the surgical department. Managers sought their opinion on clinical matters and followed this up with action. For example, equipment used in surgical theatres was provided according to staff preferences such as intravenous equipment and range of equipment stored.
- The hospital had an employee recognition scheme where good practice could be identified. Nominated staff received a thank you letter and their name was entered into a prize draw. Four winners had received a gift in the 12 months prior to the inspection. A further 26 members of staff had received long-service awards.

- The Ramsay organisation provided benefits for all their staff and rewards, such as shopping vouchers, for staff that provided outstanding care. Staff spoke of a recent 25 year celebration held for all staff at a local venue. Another member of staff had been rewarded for fundraising activities.
- The hospital was in the process of producing quality manual sharing information such as the company's strategic priorities, vision and values. Information about how quality is measured in the organisation and the Care Quality Commissions' latest findings was also included. The new quality manual was in draft form and had not yet been shared with staff.
- Regular 'bite size' bulletins were produced and shared with staff and patient representatives and provided a short summary of learning from recent incidents and complaints. There was a Freedom to Speak Up Guardian within the organisation, although they were not located at the hospital. The guardian is in place to ensure that staff can speak up when they have concerns and are supported when they do so.
- Although there were examples of positive engagement with employees, communication with theatre staff had decreased when there was no theatre manager in post during 2016 and much of 2017. Theatre staff meetings had become less frequent, for example only one meeting had taken place since June 2017. Staff also told us they had not received one to one meetings with a manager for many months. However we were also told that recently these meetings had re-commenced and they felt communication was beginning to improve. Theatre staff had either met individually with the new manager or had a meeting planned.
- The hospital sought the views of service users through surveys and a focus group. An external company conducted the patient satisfaction surveys. Survey results and complaints were discussed regularly at Clinical Governance Committee and complaints were reviewed at Medical Advisory Committee.
- The hospital held patient focus group meetings in which the survey results and actions were discussed. In the meetings they also shared governance results, such as incidents and complaints, and patient representatives could raise issues about the service and these were taken forward.
- The hospital provided comprehensive information to patients on their website about the services provided and the specialists working at the hospital. For NHS patients there were links to the NHS Choices website with the latest friends and family test results and patient comments. For private patients there was similar page where patient ratings were shown and patient comments could be reviewed.

Innovation, improvement and sustainability

- Improvement and sustainability of the surgical service was assessed and acted upon by department managers. Ward areas were being refurbished on a gradual basis according to an overall plan. Managers had assessed how facilities were used and modernisation was in progress. This included providing easy to access patient shower rooms instead of baths which would reduce risks for patients with limited mobility. Storage rooms were being increased and carpets in clinical areas were being replaced. The radiology department had undergone some refurbishment which provided greater privacy for patients in changing areas. Storage of contrast media used for certain procedures had been improved. This ensured storage was at the correct temperature and securely locked away from unauthorised access.
- There were plans to employ a deputy theatre manager which would give the theatre manager more time to work on improvements to the department and the way it was run. A date in March had been arranged to interview applicants for the post.
- The hospital had recently joined a 'Speak Up for Safety' programme. This was a Ramsay programme aimed at improving safety cultures and introducing training programmes within the hospital about developing the personal skills needed to raise issues when they are concerned about patient safety.
- The hospital's accreditation for JAG (Joint Advisory Group on GI Endoscopy) was renewed in February 2018. The JAG accreditation scheme is where endoscopy services are independently assessed against a set of recognised standards to give assurance the service is of a high standard. The hospital also had the ISO/IEC 27001:2013 certification for their patient information security management system. This means the system has been assessed against a set of recognised standards to ensure the information is managed and stored securely.
- There were new revised corporate business goals introduced for 2018 that looked at the seven business

priorities including how to grow the business and secure income. Members of the hospital's management team spoke positively about their focus on quality and safety and felt this was supported at corporate level.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must improve their processes following their investigation of patient safety incidents. This includes monitoring the recommended actions to ensure they are completed so they are assured that improvements have been made.
- The provider must ensure that all duty of candour notifications to the relevant person are made in a way that meets the regulatory requirements. This should include maintaining a clear audit trail of their decisions around duty of candour and providing the relevant person with an apology where failures have been identified.
- The provider must improve their monitoring and compliance of mandatory training.

Action the provider SHOULD take to improve

- Ensure that audits are completed in line with the organisation's audit programme. Where audits have identified non-compliance with safe processes, they should be clear about what action is required, when it should be completed and who is responsible for monitoring improvement.
- Risk assessments and risk registers should be used in accordance with the company's policy to identify, manage and escalate risks. The hospital needs to improve its oversight of new risks at relevant committees and ensure that risk assessments are completed when appropriate and kept in an accessible location.
- Consider storing documents and records relating to duty of candour in a way that is easily accessible for staff to view actions taken.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour 1. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. 2.As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must— a.notify the relevant person that the incident has occurred in accordance with paragraph (3), and b.provide reasonable support to the relevant person in relation to the incident, including when giving such notification. 3.The notification to be given under paragraph (2)(a) must— a.be given in person by one or more representatives of the registered person, b.provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification, c.advise the relevant person what further enquiries into the incident the registered person believes are appropriate, d.include an apology, and e.be recorded in a written record which is kept securely by the registered person. 4.The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing— a.the information provided under paragraph (3)(b), b.details of any enquiries to be undertaken in accordance with paragraph (3)(c),

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Requirement notices

	c.the results of any further enquiries into the incident, and d.an apology. Although there were justifiable reason, there was no audit trail relating to apparent delay before a notification and why provider had not attempted to notify them in person. Neither at the time of notification or on conclusion of the investigation was there a record the relevant person received an apology. Written records of duty of candour discussions and letters sent to the relevant person were not retained within the investigation record to ensure they were accessible.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1).Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. Senior managers could not provide assurance that they had effective systems for ensuring improvement actions were implemented and improvements had been embedded. This included for example, actions following serious incident investigations and some audits.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 2.(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

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Requirement notices

Staff compliance with mandatory training was recorded as low in areas that were essential to keep people safe. This included life support training, aseptic no touch technique and training in World Health Organisation checklist.