Duchy 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

Duchy Hospital is an independent hospital operated by Ramsay Health Care. We carried out a comprehensive inspection as part of our national programme to inspect and rate all independent hospitals. We carried out the announced part of the inspection on 11 and 12 October 2016, along with an unannounced visit to the hospital on 14 October 2016.

The hospital provided surgery, and outpatients and diagnostic imaging service to NHS patients and privately funded patients, including self-funded and medical insured. At the time of the inspection, the hospital did not provide care and treatment to patients under the age of eighteen. The surgical specialties treated were orthopaedics, spinal, urology, gynaecology, ophthalmology, oral & maxillo-facial, general surgery, gastroenterology, ENT, dermatology, cosmetic & plastic surgery. Medical specialties included cardiology, respiratory and neurology. The hospital also had an in-house physiotherapy department, X-ray & diagnostic unit and an outpatient department.

The hospital had 31 beds with 26 en-suite rooms and 12 day case beds. Facilities included three operating theatres and a day case theatre/endoscopy room, a cardiac catheter laboratory, and X-ray, outpatient and diagnostic facilities with 11 consulting rooms and two treatment rooms.

We rated the service overall as requires improvement. We rated surgery as requires improvement, and outpatients and diagnostic imaging as good. This was because we had concerns about aspects of safety at the hospital in both the surgical services, and outpatients and diagnostics services, and in the effectiveness and leadership of surgical services. We found the management of incidents, patient records, the deteriorating patient, some consent processes, resuscitation equipment, and governance processes required improvement. However, we found the service provided outstanding care for its patients and those close to them, and services were planned and delivered in a way that met the needs of the local people.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by this hospital was surgery. Where our findings on surgery for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

The hospital also had a cardiac catheter laboratory where coronary angiography investigations are carried out for patients with suspected coronary heart disease. The diagnostic imaging manager was responsible for the imaging equipment in the laboratory. Therefore information about activity in the laboratory is included in the outpatients and diagnostic imaging section.

Services we rate

We rated this hospital as requires improvement overall.

We found areas of practice that require improvement in surgery services and outpatient and diagnostic imaging:

- Resuscitation equipment and storage arrangements were not safely managed.
- The management and storage of records was not effective. Records of procedures such as invasive procedures in outpatients and the administration of intravenous fluids in surgery, were not well documented.

Summary of findings

- The safeguarding lead for the hospital was not level 3 safeguarding trained.
- Consent processes did not always follow guidelines or hospital policy.
- Governance arrangements, audit and risk management processes to monitor quality and safety within the hospital were not always effectively implemented or actions monitored.
- There was a lack of a coordinated response team for responding to medical emergencies.
- Patient leaflets and information were not available in other formats such as other languages, pictorial or braille or in large print.

In surgery:

- The management of incidents and investigations did not consistently follow the incident reporting and being open policies.
- Duty of candour was not fully implemented and did not follow hospital policy.
- The provision of cover by an anaesthetist in the 24 hours following patients' treatment was not clear.
- Mandatory training and appraisal levels were not achieved.
- The management of the deteriorating patient was poorly understood by staff, and issues where identified during audits and investigations, were not addressed.

In outpatients and Diagnostic Imaging:

- Medical records generated by staff holding practising privileges were not always available to staff (or other providers) who may be required to provide care or treatment to the patient
- It was not clear to the staff we spoke with, who the laser protection supervisor was.
- The National Safety Standards for Invasive Procedures were not yet implemented in the main outpatients department.

However,

We found outstanding practice in relation to patient care in outpatient and diagnostic imaging:

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff went out of their way to ensure patients and those close to them were involved in their care and feedback from them was continually positive.

We found good practice in relation to surgical services and outpatient and diagnostic imaging:

- The service always had enough staff to meet patients care needs and worked effectively within hospital teams, the local acute trust and ongoing services.
- Pain was managed effectively to ensure patients remained comfortable.
- Patients were well cared for and services were planned and delivered in a way that met the needs of the local population. Waiting times were minimised where possible.
- Staff spoke highly of the leadership in the organisation who were visible and approachable.

Summary of findings

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with twelve requirement notice(s) that affected surgery and outpatient and diagnostic imaging services. Details are at the end of the report.

Name of signatory

Ted Baker Deputy 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 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to Outpatients and Diagnostic Services, we do not repeat the information but cross-refer to the surgery section. The hospital provided a range of consultant-led services to patients who stayed at the hospital overnight, or visited as a day case patient. We rated this service as requires improvement, because we identified concerns relating to aspects of safety and leadership within the hospital. However, we rated the effectiveness and responsiveness of the service as good, and caring as good.
Outpatients and diagnostic imaging	Requires improvement 	The hospital provided a range of consultant-led services to patients who stayed at the hospital overnight, or visited as a day case patient. We rated this service as requires improvement. We identified concerns relating to aspects of safety within the hospital. We did not rate the effectiveness of the service. We rated caring as good, responsiveness as good, and the leadership of the service as requires improvement.

Summary of findings

Contents

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Duchy Hospital

Services we looked at

Surgery, Outpatients and diagnostic imaging.

Summary of this inspection

Background to Duchy Hospital

Duchy Hospital is operated by Ramsay Health Care. The hospital opened in 1981. It is a private hospital in Truro, Cornwall. The hospital primarily serves the communities of Cornwall and the Isles of Scilly. It also accepts patient referrals from outside this area.

The hospital's Registered Manager Mr Chris Sealey had been in post since 2003. Matron Debby Blease was Head of Clinical Services and had been in post since 2012 and was also the Controlled Drugs Accountable Officer. Vivienne Heckford was the nominated Individual.

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

The hospital was last inspected in November 2013 and was found to be compliant.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Natalie Swann, and other CQC inspectors, which included a clinical specialist Ionising Radiation (Medical Exposure) Regulations inspector and a pharmacist inspector. A specialist advisor with expertise in anaesthetic medicine also provided expert advice to the inspection team. The inspection team was overseen by Mary Cridge, Head of Hospital Inspection.

Information about Duchy Hospital

The hospital has one ward and is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning services
- Surgical procedures
- Treatment of disease, disorder or injury

During the inspection, we visited the ward, theatres, ambulatory care, consulting rooms and outpatient and diagnostic facilities. We spoke with 34 members of staff including: registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with15 patients and one relative. We also received five 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 43 sets of patient records. We held two focus groups where staff could talk to inspectors and share their experience of working at the Duchy Hospital.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in November 2013 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016):

- There were 7,867 inpatient and day case episodes of care recorded at the hospital; of these 76% were NHS-funded and 24% other funded.
- 25% of all NHS-funded patients and 35% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 33,965 outpatient total attendances in the reporting period; of these 57% were other funded and 43% were NHS-funded.

The most common surgical procedures performed during this timeframe were: adult cardiac catheterisation (1148),

Summary of this inspection

total replacement of knee joint (513), primary total hip replacement (511), injections into joint (397), diagnostic colonoscopy (387) and multiple arthroscopic operation on the knee (368).

There were 133 surgeons, anaesthetists and physicians working at the hospital under practising privileges. Two regular resident medical officers worked on a two week rota. The Duchy employed 22 registered nurses (full time equivalent) and 6.4 care assistants (full time equivalent) and a range of administrative staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the hospital matron.

The sickness rates for nurses working in theatre and inpatient departments were varied compared to the average of other independent acute hospitals we hold this type of data for in the reporting period (July 15 to June 16). The sickness rates for operating department practitioners and health care assistants working in theatre departments were mainly higher than the average of other independent acute hospitals, except for in September and November 2015. The sickness rates health care assistants working in inpatient departments were varied and notably higher during some months.

There were 54 complaints made to the hospital during the same time period and no complaints made to the CQC. The rate of complaints per 100 day case and inpatient attendances was similar to the rate of other independent acute hospitals.

Track record on safety:

- No Never Events
- Clinical incidents 131 no harm, 22 low harm, 19 moderate harm, 3 severe harm, 2 death
- 3% of all injuries were serious injuries or death

No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)

No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- There was no consistent management of incidents; policy guidance was not always followed when recording and investigating incidents. This meant not all incidents were managed and investigated the same way and learning did not consistently take place to prevent further incidents. This was a breach of a regulation. You can read more about all breaches or regulation at the end of this report.
- We identified an incident in which the duty of candour processes were not implemented. This was a breach of a regulation.
- Mandatory training for surgical services did not meet the provider's achievement target for surgical services.
- The safeguarding lead for the hospital was not level 3 safeguarding trained.
- People's individual care records were not consistently written, managed and stored in a way that keeps people safe. Procedures and processes were not always documented, the hospital did not have a comprehensive individual record for each patient (outpatients) and the medical records store posed a manual handling risk. This was a breach of a regulation.
- The provision for anaesthetist cover for patients after 24 hours post treatment was not clear and the hospital could not provide a clear example of cover in place for a given period. This meant staff may not be clear about which anaesthetist to contact for each patient. This was a breach of a regulation.
- There was a lack of a coordinated response team in responding to medical emergencies.
- The management of the deteriorating patient was shown to be poorly understood by staff with wrongly calculated early warning scores (EWS) and national early warning score (NEWS). This process had been audited and shown to have areas that required action but to date, the provider had not addressed the issues. This placed patients at risk of changes needed in their care not being identified. This was a breach of a regulation.
- Outpatient staff were not familiar with resuscitation equipment and storage arrangements made it difficult to find specific items quickly. These risks also amounted to a breach of a regulation.

Summary of this inspection

- Local rules for laser safety were not followed accurately and there was confusion about the identity of the laser protection supervisor.
- The National Safety Standards for Invasive Procedures was implemented in the cardiac catheter laboratory, but not yet implemented in the main outpatients department.

However,

- There were good standards of cleanliness and hygiene and staff complied with infection prevention and control measures.
- Staffing levels and skill mix were planned so that patients received safe care at all times.
- Risks to patients in all outpatient departments were assessed and risk management measures had been put in place in line with national guidance.
- There was an effective and well managed central sterile supplies department which supported theatres with sterile equipment.
- Staff we spoke with were clear on their roles and procedures if they had any safeguarding concerns.

Are services effective?

Good

We rated effective as good because:

- National guidelines were used to inform local policies, procedures and guidance in outpatients.
- There was evidence of multidisciplinary team working across the hospital and with the local NHS acute trust.
- Patients' pain needs were met appropriately during procedures, care and treatment.
- The there was a process for checking competency and granting and reviewing practising privileges for consultants which was implemented.

However,

- Some audits were not completed to ensure an effective service was being provided in surgery services. Furthermore, some audits, such as Venous thromboembolism audits, were left without actions and ownership to ensure follow through of actions, to correct poor audit results. This was a breach of a regulation. You can read more about breaches of regulations at the end of this report.
- We found that some missing second stage consent was not in line with organisational or national guidelines. This was a breach of a regulation.
- Not all surgery services' staff received an annual appraisal or progress development review.

Summary of this inspection

- Letters sent to GP following outpatient appointments were not included in the patient record.
- It was not possible to assess whether patients had given informed consent to some invasive procedures. This was because consent forms were kept by individual consultants, not the hospital. This was also a breach of regulation.

Are services caring?

Good

We rated caring as good because:

- Patients told us, and we observed, staff had been caring, patient and attentive throughout their treatment.
- Patients were kept informed at all times about their plan of care and their relatives and carers were encouraged and supported to be involved in the patients care.
- Patient's privacy and confidentiality was respected at all times.
- Patients we spoke to felt happy to raise concerns without fear of reproach.
- Feedback from people who used the service and those close to them was continually positive about the way staff treated them. People thought that staff went the extra mile, and the care they received exceeded their expectations. Staff would phone patients at home to make sure they had arrived home safely after difficult journeys.
- There was a strong, visible, person-centred culture. Patients were involved in how and when their treatment took place and staff always checked to ensure they were comfortable and happy with the treatment.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Nurses gave advice and support to family members as well as patients.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of local people. Staff took time to consider patients travel arrangements given the rural nature and transport within the locality.
- Facilities and premises were appropriate for the services being delivered.
- Prior to discharge the hospital ensured, as far as reasonably practicable, that onward care arraignments were in place.
- Ongoing assessments of patient needs such as mental health, physical health and nutritional and hydration needs helped promote a swift recovery.

Summary of this inspection

- A GP liaison role was established at the hospital which provided a central point of contact for general practice based staff, GPs and practice managers and facilitated access to appointments at the hospital.
- Extended appointment times were arranged for patients with complex needs.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The hospital consistently exceeded the NHS 18 week waiting time to treatment target during the year ending July 2016.
- When complaints or concerns were identified patients were given the opportunity to discuss this with the relevant department manager or matron.

However,

- Letters and information sent to patients was not available in alternative formats such as other languages, pictorial, braille or in large print.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Not all staff were aware of the hospital's vision and strategy for the service.
- Assurance process and governance frameworks were not always effectively implemented or monitored and did not support the delivery of the strategy and good quality care.
- Not all policies and procedures were adhered to. Audit and monitoring was not assuring the hospital provided a safe and effective service. We reviewed information and data contained in the hospital's audit system which related to the previous 12 months prior to the inspection. We found actions were not always identified in audits where results were concerning. It was not always clear from the audit who was responsible for taking actions forward and there was a lack of consistency in managing gaps identified within the audit. This was a breach of a regulation. You can read more about breaches of regulation at the end of this report.
- The risk register did not adequately prioritise clinical risk and was focused more on commercial risk within the hospital. The register did not appear comprehensive enough to address current or future risks.

Summary of this inspection

- It was clear in our review of patient records, a root cause analysis investigation, and audits, that the management of the deteriorating patient was poorly understood by staff and issues, where identified in audits and investigations were not addressed. This was a breach of a regulation.
- Although there was a well established governance framework, plans for the introduction of National Safety Standards for Invasive Procedures (NatSSIPs) had been delayed in the main outpatients.

However

- Managers were aware of the need to increase awareness of the vision and strategy for the service. However, staff understood the provision of a quality service, where the reputation of the hospital and the patient experience was of high importance.
- Leaders were visible and approachable. They encouraged supportive and appreciative relationships among and with staff.
- There was a culture of developing staff which was frequently referred to as 'growing your own'.
- Outpatient managers were clinically active in their departments. Staff told us they were approachable and supportive.
- Staff enjoyed working at the hospital, were recognised and rewarded, and were focused on providing patient centred care.

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	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- In the reporting period (July 15 - June 16) there were a total of 77 clinical incidents for surgical and inpatient services which accounted to 44% of all reported incidents for the hospital, which is lower than other independent acute hospitals.
- In the reporting period (July 15 - June 16) there were 31 reported serious incidents.
- Staff told us they understood their responsibility to record safety incidents, concerns and near misses onto the hospital's electronic incident recording system. All staff, including bank staff (staff who did not work permanently at the hospital) were provided with an email account which gave them access to the electronic incident recording system. Following a mock inspection in 2016 carried out by Ramsay staff, it was noted in the May 2016 heads of department meeting minutes that only a very small number of Duchy staff used the electronic incident recording system for incident reporting. Senior management confirmed they were supporting staff with training and through peer support. However, no formal training programme had been developed, to ensure more staff were able to input incidents onto the electronic incident recording system. Prior to this, staff would inform other colleagues or a manager to record incidents onto the system. It was noted in the meeting minutes the number of incidents being added to the system was increasing.
- The Ramsay Incident Reporting Policy stated that incidents and complaints should be linked as this ensured that if an incident was identified as a result of a complaint, the incident would also be recorded onto the incident reporting system to ensure incident reporting was accurate. However, in one of the six complaints we reviewed during the inspection, we found that whilst the complaint had been investigated and learning in subsequent departmental and clinical governance meetings had been provided. However, this incident was not recorded onto the incident recording system. This did not follow the provider's policy.
- Incidents were coded using the Ramsay corporate coding where one was the most severe and four the least severe. All staff were able to override the rating if they felt it was appropriate.
- When things went wrong, investigations were not always carried out in line with the provider's policy. Ramsay policy stated all level one and level two incidents required a root cause analysis level of investigation. A root cause analysis investigation is a systematic investigation in which factors which contributed to an incident are identified, a root cause found where possible and learning and actions to be taken are identified. During the inspection, we requested the root cause analysis for five level two incidents. All of these incidents were investigated but only one was investigated using a comprehensive root cause analysis. Therefore, serious incidents were not routinely investigated in line with the provider's incident reporting policy. We raised this during the inspection and Matron confirmed that level two incidents would be investigated, but a root cause analysis methodology would not always be employed. There was no current decision making tool in place, or further guidance

provided in relation to how this decision to use a root cause analysis, or not, was made. Furthermore, a departmental manager confirmed they carried out root cause analysis investigations, but had not yet received training in how to do this.

- In an investigation that did use a root cause analysis methodology, we found that observations of the patient that did not follow protocol. However, this was not identified during the investigation. The National Early Warning Score (NEWS) used to detect clinical deterioration in acutely ill patients was also calculated incorrectly, which meant there was a risk of the patient not receiving the care needed. This was also not identified in the root cause analysis investigation. This did not provide assurance that incidents were being investigated effectively, or with the use of a recognised tool, as outlined by the Ramsay policy.
- Matron explained during a recent review of incidents, a shortfall in hospital-wide learning was identified, and resulted in the suggestion of a learning log, in order to further capture learning from incidents. However, it was not clear whether all staff were accurately recording the number of incidents onto the electronic incident recording system when identified in the hospital, or through complaints raised within the service.
- All incidents recorded onto the incident recording system were overseen by matron who received an alert when a new incident was added, in order to give an initial review of the incident. There was a corporate level of insight into incidents recorded onto the system, which allowed the corporate team to comment on incidents recorded at a local level. Comment such as these could be viewed within incidents recorded by staff at a hospital level.
- Staff told us they received learning from incident. Staff provided examples of how managers had approached them to discuss incidents they had raised with their seniors or had added to the electronic incident recording system.
- Clinical and non-clinical staff from different areas of the hospital confirmed they received feedback and learning from incidents at departmental meetings and from line managers.
- There had been two unexpected deaths reported to the CQC in the reporting period (July 15 to June 16). When deaths occurred, we were told these would be reviewed and discussed at the clinical governance meetings. We reviewed meeting minutes, which confirmed mortality reviews took place within the clinical governance committee meetings, where serious incidents, complaints and clinical outcomes were also discussed.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014 and in April 2015 for independent providers. This Regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident, and offer an apology. It is applicable, even if an incident occurs which is a known risk. The patient should be provided with an apology, support and an explanation of what went wrong. They should be kept informed about any enquiry/investigation into the incident and a plan to try and medically repair or redress the harm done. A written copy of these steps should be provided to the patient, and a copy kept in the patient's records, along with any subsequent correspondence.
- Duty of candour was not fully implemented and did not follow hospital policy. Staff were familiar with the duty of candour regulation, but had varying degrees of understanding of when it would be applied.
- We identified an incident that occurred during surgery which was classified as moderate harm, and required further treatment and investigation. We could not find a record in the patient's notes of any discussion with the patient that demonstrated the duty of candour regulation was met. Following the inspection, we asked the provider to supply copies of any correspondence that would confirm this process was followed. We were informed the patient's surgeon and consultant had spoken with the patient following the procedure, to apologise and explain what had occurred. However, we were informed written confirmation of this was by way of a copy of a discharge letter which was addressed to their GP. This did not follow the hospital's Being Open policy or the duty of candour regulation. Subsequent to our request, the provider sent a copy of a letter to the patient which included an apology and confirmation the incident was discussed with the patient at the time of

the event, but no further detail of an enquiry/ investigation. Furthermore, this was a notifiable safety incident which had not been reported to the CQC. This did not follow the hospital's Incident Recording policy.

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

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. The hospital collected monthly data for the NHS safety thermometer. The NHS safety thermometer is a collection of data submitted by all hospitals treating NHS inpatients. The data collected is a snapshot of inpatients suffering avoidable harm, usually on one day each month. The NHS safety thermometerallows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, catheter-related urinary tract infections and venous thromboembolism (VTE).
- The hospital provided no specific data in relation to the safety thermometer. However, it reported, NHS safety thermometer results consistently demonstrated that care was harm free.
- During our inspection, we found no visible information for NHS patients showing how the hospital was performing against the safety thermometer. Although the hospital collated information for the NHS safety thermometer, this was not displayed for patients to see in line with best practice."
- For patients who were privately funded, safety issues were monitored through the audit programme. This included VTE, where ten patient records were reviewed quarterly.

Cleanliness, infection control and hygiene

- A health questionnaire was given to patients prior to their surgery which assisted in risk assessing patients for infections. In the period (July 15 - June 16) there were no incidences of Methicillin Resistance Staphylococcus Aureus (MRSA), Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile and Escherichia coli.
- In the reporting period (July 15 - June 16) there were nine reported surgical site infections. These were split with three in hip arthroplasty, three in breast procedures, one in knee arthroplasty and two in other orthopaedic or trauma procedures. The rate of infections during primary hip arthroplasty and breast procedures was higher than the rate of other independent acute hospitals we hold this type of data for. The rate of infections during primary knee arthroplasty, other orthopaedic and trauma was similar to or lower than the rate of other independent acute hospitals. There were no surgical site infections resulting from revision hip arthroplasty, revision knee arthroplasty, gynaecological, upper GI and colorectal, urological, cranial or vascular procedures.
- In the patient rooms we saw there were no clinical waste bins therefore increasing the risk of contaminated waste issues from patients removing their own dressings. We were told if nurses had to do wound dressing changes then clinical waste bags are taken in with the nurse and disposed of outside of the bedroom. However it was Ramsay Company Policy not to have dedicated clinical waste binds in the rooms.
- There were no ward sinks for staff to wash their hands between patients. This meant staff would have to share the sink in the patient rooms. Hand wash and paper towels were available however, this practice is not in line with the department of health building notes on infection control in the built environment section 3.41 which states "Hand-hygiene facilities should be readily available in all clinical areas. There should be sufficient numbers and appropriate sizes of clinical wash-hand basins to encourage and assist staff to readily conform to hand-hygiene protocols".
- Hand hygiene audits were completed for October 2015 and April 2016 and showed departments were maintaining their targets.
- We observed staff following infection prevention and control procedures by using correct personal protective equipment and hand gels. Staff were bare below the elbow.
- It was a corporate policy to install carpets in patients' bedrooms, while this was not in line with recommended best practice; a process was in place which required carpets to be steam cleaned if the patient stayed in a room for more than two days. Most rooms were fitted with carpet tiles which meant any spillages or damage to patches of carpet that could not be cleaned effectively or repaired, could be rectified by replacing the carpet tile. We saw the hospital had supplies of replacement carpet tiles, should they be required.
- A record and audit of room cleaning was instigated through the operations manager and a cleaning matrix was kept on the wall of the ward. There was a schedule in place for staff to sign off, which at the time of inspection had been completed and was up to date.

- A service level agreement was in place so that ward staff could work effectively with cleaning staff to ensure areas were cleaned effectively. For example, ward staff agreed to ensure shelves were kept clear and ready for cleaning, and to not store items in a way that would create a manual handling risks for cleaners. The Patient Led Assessments of the Care Environment (PLACE) scores for cleanliness and hygiene was 100%.
- The central sterile supplies department (CSSD) ensured theatre instruments were sterile and available for use. The CSSD used a recognised tracking system for all instruments used in surgery to ensure a trackable audit history for the instruments.
- The hospital monitored surgical site infections. They relied on being informed by patients or other healthcare providers as well as patients attending post-operative physiotherapy and outpatients had pro-active wound checking. All potential infections were reported on the electronic risk management system. The provider participates in National Surgical Site Infection Audits as well as Ramsay HealthCare audits.
- The hospital was joint advisory group (JAG) accredited for its endoscopy service. JAG accreditation is the formal recognition that the provision of endoscopy has met the required standards and demonstrated competence in this service.
- The hospitals endoscope washers are dated and nearing their end of the service period. These washers are on the hospitals risk register and require replacing.

Environment and equipment

- We saw resuscitation equipment available in each area of the hospital including the ward, theatres and recovery. Both ward resuscitation trolleys were inspected and we found the suction unit on one trolley and a blood pressure cuff on another had expired their service dates.
- We saw hoists that were used to transfer patients and included different weight rated straps, these were in service date. Should a patient require moving in excess of that weight, then alternative hoists would need to be sourced.
- Storage in theatres was limited and products were stacked on racking above head height. This had the potential to increase manual handling injuries.
- Equipment recalls and safety alerts were sent to the heads of department and team leaders via email. The alert was then printed and passed to each member of staff who had to sign to say they had read this information. This ensured staff remained up-to-date with latest safety alerts and that they were actioned promptly.
- We saw theatre cleaning lists were implemented, followed and signed off by the individual once completed.
- Staff had good access to equipment and could discuss equipment needs with line managers, at forums and with cleaning and maintenance services.
- The operations director and an engineer oversaw safety alerts in relation to maintenance, food and equipment. We were provided with an example that demonstrated staff responded in a timely way to such alerts.
- Faults with equipment were recorded onto an electronic incident recording system. Staff could access this to remain updated about repairs or replacements. A sticker would also be placed on the equipment to mark when it was reported to the engineer.
- The hospital used feedback gathered through the Patient Led Assessments of the Care Environment (PLACE) audit to ensure it responded to issues raised. For example, a wheelchair user provided feedback which the hospital actioned, this included new ramp access at the front entrance of the hospital.
- The PLACE audit showed that Duchy hospitals scored the same or above the England average for condition, appearance and maintenance scoring 99%.

Medicines

- There was a comprehensive corporate medicines management policy including controlled drugs, last reviewed in October 2014.
- There was no pharmacy support on site. The pharmacist from the local acute trust visited the ward three times a week, for one hour each visit, but did not have time to look at every prescription chart. The Pharmacist conducted a sense check of the prescription chart and checked the patient's own medicines that they had brought in.
- Staff said there was an open culture for reporting medicine incidents using the electronic incident recording system. The investigations were fed through to the Clinical Governance Committee and the Medical Advisory Committee. The corporate pharmacist also reviewed all reported medicine incidents.

- Matron could explain the action taken if medicine errors were made; these included reflective practice, supervision and disciplinary action.
- Patients were allowed to self-administer inhalers and insulin once they had been assessed as fit to self-medicate.
- Medical alerts were received via e-mail were distributed to nurses by ward managers to provide information and updates.
- The hospital has a contract with a local acute trust who supplies controlled drugs and some specific medicines. There was a controlled drugs cupboard in each anaesthetic room. The hospital ordered controlled drugs from the local acute trust, all of which were countersigned on administration or receipt by a consultant. The controlled drugs records book had a record of all medicines supplied, administered and destroyed. All entries had two signatures.
- We found a large store cupboard for the bulk of medicines stock in the general theatre area not locked (the padlock was on top of cupboard). There was a sign on the door to remind operating department practitioners to lock the cupboard door when theatre area was not staffed. Only authorised theatre staff had access to the theatre area via a swipe card system, however the open access to this cupboard did not provide or enable and audit trail of access to the cupboard should it be needed.
- We looked at seven medicines charts (four on the ward and three in patient notes) and they were correctly completed.
- Discharge medicines were written by the Registered Medical Officer on a discharge form. If the patient needed something unusual the discharge form was faxed to pharmacy. Labels were appropriate and the ward has a supply of patient information leaflets about pain.
- We viewed seven medicine charts and found batch numbers and expiry dates for intravenous fluids were not routinely recorded and no audit trail for previously administered fluids was kept.

Records

- We saw that each patient had their own care record; this consisted of the pre-assessment information, any investigations and results from these. Relevant risk assessments were also completed. The record was updated as the patient progressed, with additions from preoperative checklists, anaesthetics and later post-operative care such as physiotherapy.
- A clinical record keeping policy was in place and in date which gave guidance as to the correct completion of patient records and was due for renewal in March 2017. The policy advised staff of their responsibilities when removing records outside of Duchy Hospital. Senior staff confirmed that the removal of notes by surgeons was not normal practice.
- We reviewed 18 sets of records and found them to be completed and readable. Entries relating to the patient's time in theatre were fully completed and included the World Health Organisation (WHO) safety checklist undertaken during surgery. The date and time of procedures was recorded and included the bar code for any implant or prosthesis used.
- One record we reviewed showed that due to a perforated bladder during surgery a catheter was inserted for 14 days. When we asked the hospital about this we were told the consultant had spoken with this patient. We could see no documented evidence that this was explained to the patient as nothing had been written in the patient record.
- Anaesthetists maintained a clinical record and these were stored in the patients' medical records held on site during any procedure and stored securely on site after treatment was completed.

Safeguarding

- All staff had completed level one safeguarding for children as part of their induction and ongoing mandatory training in such areas such as female genital mutilation. However at the time of inspection it was shown that only 77% of staff were up to date with safeguarding of adults at level one, but 98% were up to date with safeguarding adults level two. At the time of this inspection Duchy hospital did not take children.
- Matron was currently not level three safeguarding trained, but was the safeguarding lead for the hospital and would link with external agencies for concerns that arose. If Matron required further internal support she would contact the safeguarding lead for Ramsay Health Care who was trained to level five safeguarding.
- There were no been no safeguarding concerns reported to CQC in the reporting period (July 15 to June 16).

- While we were conducting our inspection we witnessed safeguarding concerns related to a patient raised by nursing staff and passed to matron. The hospital then engaged the relevant external agencies to ensure the necessary procedures were addressed.

Mandatory training

- Staff were expected to attend a suite of mandatory training sessions such as basic and immediate life support, moving and handling, fire safety, infection prevention and control and safeguarding. Each department had a digital log of staff and their current competencies and those requiring updates in their training. At the time of our inspection surgical core services overall compliance was at 52% for theatre staff and 81% for ward staff. Work was ongoing to achieve full compliance.
- Staff were allocated one day per month to carry out mandatory training. This year, staff said training had to be scheduled into their rotas one month in advance.
- Staff said managers afforded them the time to complete mandatory training. Staff were able to complete the electronic learning programmes online at home if necessary and were able to take the time back. For example, some staff who had additional specialist roles, described as link roles, and may not always have had the time to complete this whilst at work were able to complete this at their convenience.
- Duchy hospital had recently changed from using the early warming score (EWS) for identifying and managing the deteriorating patient to the national early warning score (NEWS). Current training compliance for ward and recovery staff was 100% and the ambulatory care unit 87 % (seven of eight staff completed).

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

- Duchy hospital performed a pre-assessment of patients. This looked at patient's current health status. Risk assessments were completed to manage potential risks of venous thromboembolism, nutrition, falls risk and pressure sores. If a patient presented a risk from these assessments, nursing staff would record and review the information. All results were reviewed in pre-assessment and by the consultant for the suitability of the surgical procedures given the risks posed by the patient's current health. Duchy hospital has increased their intake of patients with complex needs therefore adapted the pre-assessment process to accommodate these needs.
- Patients' attending the ambulatory care unit also completed the pre-assessment process which was reviewed again on the day of the procedure to see if any changes had occurred since the initial assessment.
- A registered medical officer (RMO) was in place to provide medical support for the deteriorating patient. Nursing staff would contact the RMO when triggers were reached on the NEWS chart or concerns were identified, the RMO would in turn contact the consultant or anaesthetist assigned to that patient where necessary. A service level agreement was in place to transport patients that required transfer to a local acute trust.
- We observed theatre staff following the World Health Organisation (WHO) safer surgery checklist. Theatre staff followed a pre-set list of instructions that are signed off to show completion. We saw these checklists in both theatres and the anaesthetic room and they were completed fully. We saw both a team brief before the start of a procedure and a de-brief at the end. These were in place to ensure staff had an understanding of any issues and had the opportunity to raise any questions.
- We saw four WHO surgical safety audits from 2015/2016. We noted that in August and November 2015 the audit showed a compliance of 97%, with gaps mostly for failing to sign or initial in the correct areas. By February and May 2016 the audit showed an improvement to 100% in all areas.
- We reviewed the anaesthetic standards audit which had been completed six monthly. Ten sets of records were audited and for September 2015 and again in March 2016. In September 2016 the overall results were 90% however within the audit there were non- compliances in oxygen prescribed correctly on the drugs chart, recording of fluid balances, and the recording of weight height and basic vital signs. The audit concluded that an email would be sent highlighting where they were deficient. The following audit in March 2016 scored only 83% with an action for this to be brought to the attention of the Medical Advisory Committee and the anaesthetic representative. We reviewed the July 2016 (subsequent) Medical Advisory Committee meeting minutes, but did not see that this issue had been discussed.
- The management of the deteriorating patient was poorly understood by staff and issues, where identified in audits and investigations were not addressed. The deteriorating patient scoring system is rated in

increasing numerical order. As the numbers cross a certain threshold clinical actions are triggered such as contacting the resident medical officer or the patient's consultant. A management of the deteriorating patient audit took place in September 2015 which looked at ten records. It scored 100% in all areas except for contacting the correct person according to the track and trigger flow chart which scored 90%. However, in March 2016 the audit showed an increase in non-compliance, with a rate of 80%.

- Systems to identify the deteriorating patient were not implemented effectively. National Early Warning Scores should be used for initial assessment of acute illness and for continuous monitoring of a patient throughout their stay in hospital. Recording the NEWS on a regular basis, helps to monitor a patients' response to treatment. It can be tracked to provide early warning of potential clinical deterioration and provide a trigger for escalation of clinical care.
- Where deteriorating patient scores were calculated, actions were not being taken to respond appropriately to these scores to ensure patient safety. For example, the March 2016 audit scored 89% when assessing if the score had been calculated for each set of observations. The audit showed that where the patients' scores indicated the patient was deteriorating, appropriate actions to escalate this were not taken. The audit scored 43% in the section relating to 'if any total equals one or two, or one in any single parameter, is there written evidence that all actions according to the track and trigger flow chart has been carried out. The audit had no actions allocated or ownership given to improve standards. Matron confirmed to us, the focus was on the overall score of each audit rather than the individual issues identified within sections of the audit. This meant specific areas of risk were not being targeted for action or improvement.
- In nine of the 18 sets of records we reviewed, we found omissions of patient observations in the early warning score (EWS) and national early warning score (NEWS), or where the forms were incorrectly completed. This made the total score calculated incorrect. Therefore, we were not assured that the appropriate action was taken for those deteriorating patients.
- Furthermore, we did not consider that two audits in 12 months, selecting ten records each time, provided an adequate overview of the standards and assurances of safety, given the large number of patients being treated at the hospital.
- Within the 18 notes we looked at there were regular omissions from the anaesthetists to record patient temperatures during a procedure. Often no patient temperatures were recorded for patients who had been anesthetised for over an hour. Of the 18 notes we inspected nine had no records of patient temperature for procedures over 30 minutes duration. NICE guidance CG65 1.3.1 states "The patient's temperature should be measured and documented before induction of anaesthesia and then every 30 minutes until the end of surgery." Without this monitoring patients have the potential to become hypothermic.
- There was a lack of clarity in relation to the anaesthetic rota after the first 24 hours following surgery. The hospital's Medical Advisory Committee lead confirmed professional responsibility for continuing care of the patient lay with the surgeon for the entirety of the patients stay and with the anaesthetist within the first 24 hours. The surgeon would then be responsible to call the anaesthetist in if the patient's condition declined, or needed to be returned to theatre. If unavailable, a 'buddy' would be identified and contacted. On call arrangements were said to be written on a white board however we looked at this board during the inspection and it was blank; this also meant that there would be no audit trail of the on-call anaesthetist when this was wiped clear. We could find no formal rota in place.
- There was a standard procedure in place for venous thromboembolism (VTE) risk assessments and staff said anticoagulant prescribing followed the local acute trust guidelines.
- We reviewed four VTE audits from August and November 2015 and February and May 2016. There was some improvement through these audits and in May 2016 the audit showed 98% compliance with one of the ten areas of the audit scoring 80%. This line related to where the surgeon was to review the VTE assessment and ensure it was fully completed. It was noted however that in the previous audit in February 2016 a consultant had used a post-operative VTE prophylaxis that was not in line with National Institute for Health and Care Excellence (NICE) guidance yet the audit failed to action this or assign ownership to this non-compliance.

Requires improvement

Surgery

- Duchy hospital conducted cosmetic surgery and we were assured that access to a psychologist was available to cosmetic surgeons who had concerns around patient's suitability/stability for their desired surgical procedure. Indeed the psychology service was available to all Duchy patients should their managing consultant feel it would be helpful, beneficial, and aid to decision making.
- All patients attending for potential bariatric surgery were first assessed by a clinical nurse specialist and specialist dietician with a view to surgery. Should either of the professionals have concerns these would be raised with the weight loss surgery Consultant and referred to the psychologist for assessment prior to any decision to proceed to surgery.
- Patients who had been discharged were given a telephone number to call should they have any concerns which was staffed day or night.
- The process for responding to medical emergencies did not follow the hospital's policy. There was no dedicated emergency resuscitation team to respond to medical emergencies. The hospital's policy stated a team must be nominated, which should consist of one doctor and no fewer than three registered health care professionals at all times. Staff we spoke with said if an alarm was sounded, all staff available would respond and the attending RMO would allocate resuscitation roles and dismiss surplus staff. The Duchy resuscitation policy also stated "The response of bleep holders will be recorded by switchboard and periodically audited by the resuscitation co-ordinator." However, no records of audited response times were present in the Duchy audit programme.

Nursing and support staffing

- Duchy Hospital utilised Ramsay's staffing guidance and calculated staff requirements to patient numbers and included patient dependency levels. Staff rotas were managed electronically by Ramsay's own electronic health roster system. Rotas were reviewed both daily and weekly to ensure safe staffing.
- Theatres used the electronic staffing system to ensure safe levels of staffing. In theatres there were 34 staff working variable hours, the theatre team used some bank and agency staffing. Agency staff were managed by Ramsay assured agency staffing.
- In the reporting period (July 15 to June 16) the use of agency nurses and health care assistants was lower than the average of other independent hospitals.
- Nursing staff said managers looked at staffing rotas on a daily basis as the amount of patients could change daily. Where able, managers had access to extra staff when needed. For example, if a patient living with dementia needed more one to one care, extra staff could be rostered on duty to ensure safe care and treatment. Clinical and non-clinical bank staff could also be employed when needed, such as during periods of sickness of staff shortages.
- At the time of our inspection theatres were well staffed and recovery had safe staffing levels to meet the theatre list activity as per AfPP (Association for Perioperative Practice) guidelines.
- Out of hours, for patients that required a return to theatre, there was an on call team that rotated each week.

Medical staffing

- Both consultant and anaesthetist were involved with their patient's care from pre-assessment, through to post-operative care. They were also on call at evenings and weekends until their patients went home.
- To be granted practising privileges at the hospital, the consultant needed to be able to reach the hospital in an emergency within 30 minutes. We looked at two incident investigation reports, and in one instance the consultant was not on site until 45 minutes after recall to theatre.
- The anaesthetist was also to remain on call for the patient. It was the responsibility of the anaesthetist to ensure they were covered if they became unavailable and the patient was required to return to theatre. At the time of our inspection we found the process was not clear for ensuring who was the on call anaesthetist.
- Resident Medical Officers were provided by an outsourced agency, and were available on site 24 hours a day for the period they were on rotation - 14 days on/ off. The RMO had access to support by telephone to the RMO agency should they have any questions or concerns, however in normal working hours the RMO could liaise with Matron initially if they wished.

Emergency awareness and training

- Duchy hospital had a business continuity plan in place; it was due for review in August 2016. Within this policy it

explained the roles and responsibilities of staff in the event of major incidents. Staff we spoke with were aware of their roles on the wards, theatres and ambulatory care unit.

- A new policy had been introduced which required a fire drill to be carried out twice in the year so that it could include night staff. Senior management said that planned and reactive fire drills were practised and learning from these shared where appropriate. For example, a letter was sent to consultants recently to ensure they responded to fire alarms appropriately, and for staff to use a buddy system of checking other colleagues were clear of the building during an alarm. This was discussed at the risk management committee.
- The hospital had an all-terrain vehicle which it could use in the event of adverse weather. It was purchased when serious snowfall had occurred six years ago. Arrangements were made so that staff who could walk to the hospital were known, or could stay overnight if required. There were arrangements where staff with suitable vehicles could collect other staff members.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Staff received updates around changes to policies or guidelines in a clinical update newsletter that was emailed round on a monthly basis.
- The hospital participated in a number of national benchmarking audits. Where patients were having hip or knee procedures, if they consented, the data was submitted to the National Joint Registry. This information allowed monitoring by the NHS how joint replacements performed over time. Duchy hospital also participated in Patient Reported Outcome Measures (PROMS) for hips and knees.
- Cosmetic surgery practice was not monitored to ensure practice was in line with the Professional Standards for Cosmetic Practice-Cosmetics Surgical Practice Working Party, Royal College of Surgeons (RCS Professional Standards). There was no audit to monitor compliance to the RCS Professional Standards to provide assurance relating to compliance, or to identify any areas for improvement.
- Duchy Hospital ensured that National Institute for Health and Care Excellence (NICE) guidelines were distributed to all consultants and heads of department quarterly. Care pathways were evidence based, and related to recent national guidance. For example, NICE CG50: Acutely ill adults in hospital: recognising and responding to deterioration.
- VTE prophylaxis for post-operative patients is recommended as per NICE guidance CG92 to reduce the chance of post-operative complications (which can be severe or on occasion result in death) such as Deep Vein Thrombosis or Pulmonary Embolism. We saw from audits that improvements were made over the reporting period to engage consultants in reviewing VTE prophylaxis post operatively. However, as with several audits that had significant non- compliance, we noted that actions, ownership and completion dates were not implemented. It was raised in the April 2016 clinical governance meeting that this needed to be raised in the Medical Advisory Committee meeting to ensure any deviation from policy and current guidelines would be addressed. However, in the July 2016 Medical Advisory Committee meeting minutes, the lack of compliance was raised to say consultants were not compliant, but it was not clear what actions were being taken to address this. Therefore it was not clear as to how the service ensured it followed NICE guidance.

Pain relief

- Pain was monitored on regular basis in all stages of the patient's stay. Pain was monitored using a pain score card (0-10 pain score, with 10 being the highest level of pain) this was then recorded in the patient records and the pain dealt with as appropriate and as prescribed by the consultant.
- We spoke with three patients about pain management and all felt they had their pain managed well. All three were confident that any questions related to pain management at home were well addressed and they felt comfortable to ask if unsure.

Nutrition and hydration

- Staff ensured patients received a good standard of nutrition and hydration and often and said they would accommodate individual needs where possible. For

example, a diabetic patient who did not find their desert appetising raised this with staff. As a result nursing and catering staff worked together to make a cake suitable for the patient. Concerns had also been raised between staff about a patient who was showing little interest in their food due to their medical condition. As a result a member of staff drove to a nearby supermarket out of hours to ensure the patients both received something to eat that they had expressed an interest in eating, and so enabled them to have sufficient diet.

- Two nutrition and hydration audits had been conducted within the reporting period (July 15 to June 16). Both audits scored 97% in December 2015 and 93% in June 2016. When we reviewed the 18 sets of patient notes we found they reflected the scores.
- For patients who were required to have fast (be nil by mouth) prior to a procedure, we saw this was noted in pre-assessment. It was here that the patient was told that no solid foods were to be consumed six hours prior to surgery and fluids two hours prior to any anaesthetic. On admission staff would ask patients when they last ate or drank prior to surgery and this was recorded in the patient's notes.

Patient outcomes

- The Hospital shared information to the National Joint and Ligament Registries and Patient Related Outcome Measures (PROMS).
- Duchy Hospital's PROMS data showed that in the period April 2014 to March 2015 that primary knee replacements scored better than the England average. They reported that out of 217 records 54% were reported as improved and 31% as worsened on the Oxford knee score which was significantly better than the England average.
- The Oxford primary hip replacement score showed that out of 386 records 98% were reported as improved and 1% as worsened.
- In the reporting period (July 2015 to June 2016) there were 20 cases of unplanned transfer of an inpatient to another hospital. We could find no clinical trends. However, we could not be assured if a link between the management of the deteriorating patient and cases of incorrect completion of National Early Warning Scores or Early Warning Scores charts had an impact on these transfers.
- In the same period there were also 19 cases of unplanned readmission within 28 days of discharge. This rate is not high when compared to a group of independent hospitals.
- There were no outcomes recorded for cosmetic procedures. Whilst the organisation was collating information in relation to implants used in cosmetic surgery on a register, it did not have evidence to support the outcomes for patients for cosmetic surgery procedures. We saw no evidence from patients of complaints or concerns in relation to cosmetic surgery, but no evidence from the service to support good outcomes.

Competent staff

- In order to manage the increasing complexity of patients, the Medical Advisory Committee confirmed that a higher level of resident medical officer was employed.
- In 2016, the hospital began a new service by offering spinal procedures. We were told the skill mix of staff was reviewed in order to effectively and safely manage care of patients undergoing these procedures.
- The Medical Advisory Committee chair stated that patients with higher care needs and dependency were reviewed and admitted on a case by case basis to ensure that staff had the skills to meet their increased needs. Matron told us the hospital was assured that staff had sufficient skills to manage the increasing number of more complex patients being admitted to the hospital, due to their wide ranging backgrounds.
- Staff were forthcoming with examples of how they were able to access training and development both within and outside of the hospital. For example, a nurse was completing a critical care course at the local acute trust in light of the increasing complexity of patients being admitted at the hospital.
- Managers carried out six monthly performance development reviews (PDR's) with staff and appraisals scheduled to take place on an annual basis. At the time of the inspection progress development reviews for the surgical services (theatres and ward) stood at 82% completed.
- The performance development reviews (PDR's) were broken down further into clinical and non-clinical compliances. While the wards were at 100%, theatres were at 70% for clinical compliance.

- A performance management process and policy was in place in order to manage poor or variable staff performance. Heads of department would raise any concerns early with staff who could also talk to the human resources department, along with their head of department. Managers could access corporate support with any issues if needed.
- The Medical Advisory Committee chair reviewed the resident medical officer's skills and was involved in their appraisal. Matron would also review the resident medical officer's skill set.

Multidisciplinary working

- We found that staff communicated well between departments. Handovers were thorough and passed over concise patient information.
- We witnessed a morning staff handover where staff discussed issues and priorities for the duration of the shift; this included patients' needs between bed rest and mobility in discussion with nursing staff and physiotherapists.
- The consultant handed over any information they felt relevant to the Resident Medical Officer (RMO) before leaving the hospital. The RMO could contact the consultant at home if required.
- We saw staff liaising with patient's families prior to discharge to ensure suitable care and provision was in place, staff also worked closely with the GPs.
- The involvement of other teams and services to plan ongoing care and treatment beyond the hospital was planned for during the pre-assessment process. For example, staff would establish the level of involvement of family, social services, ongoing nursing care in nursing homes or community hospitals throughout their care. Staff were able to carry out visits to nursing homes where necessary. Where patients were referred to a community hospital following their stay, a verbal handover discussion took place.
- The hospital worked effectively with other organisations and services outside of the hospital to ensure effective ongoing care and treatment. For example, staff liaised with other healthcare professionals to ensure a patient who experienced a complication which required a referral to services outside of the hospital, had a referral in place by the time the patient left the hospital. This meant staff were able to assure the patient about their ongoing care and treatment plan without delay or unnecessary anxiety this could cause the patient.

Seven-day services

- Duchy hospital provided elective surgery Monday to Saturday from 8am to 8pm. Staff were aware of the patient lists several weeks in advance to enable staffing levels and rooms to be available.
- Nursing staff and the Resident Medical Officer were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of senior management was available to support staff as part of an on call rota.
- Surgical services were able to access support from other health care professionals out of hours. A radiographer was available and was contactable out of hours. There was access to a physiotherapist.
- There was an out of hours on call theatre rota available including the patient's consultant if a patient need to return to theatre.

Access to information

- Nursing staff were able to access policies and procedures both electronically via the corporate intranet and in paper form if required. This access enabled staff to check and confirm any provider policies.
- Each set of patient notes had two sections; one was kept in the patient's room that consisted of observation charts and information about the procedures, the other was stored securely at the nurses' station. This had consultant notes and operation details.
- Patient records were kept onsite and were stored in a secure office. Consultants were instructed not to remove records from the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Duchy hospital had a pre-assessment process that would identify those without the mental capacity for consent. In the eighteen records we reviewed all patients were deemed to have the mental capacity for consent.
- There was a consent policy in place and reviewed in June 2016. The policy set out how consent was to be gained and taking into account the mental capacity of the individual to give that consent. The policy also covered the use of removed tissue and consent regarding the use of photographs, filming and audio recordings. However, we reviewed patient notes and audit data and found consent process did not always follow the hospital's policy.

- Consent procedures were not always implemented. Some procedures require a two stage consent process. This second stage of consent gives the patient the opportunity to change their mind about having the procedure. Initial consent (consent form one) was completed with the consultant, then again during preparation for the procedure (consent stage two). We found in four out of five records we reviewed, the second stage of consent to be missing. Without this section being completed with the patient, we were not assured the hospital was gaining this second stage of consent or that the patient had been given adequate time to change their mind.
- The process for seeking consent was monitored through audit. Four Audits for consent were conducted in the reporting period (July 15 to June 16) September 2015 scored 86%, December 2015 scored 83%, March 2016 scored 99% and June 2016 scored 89%. In each audit a failure in the stage two consent was consistently low scoring. While it was actioned twice, the results of the audit showed the actions had little effect to prevent reoccurrence. This means that the provider had not met its responsibilities within legislation, or followed relevant national guidance for consent.
- Mandatory training for the Mental Capacity Act 2005 awareness was included within the safeguarding level two eLearning package, at the time of our inspection 90% of those staff required to complete it had done so.
- A deprivation of liberty safeguard policy was in place and last reviewed in January2016. The policy described the procedures in place should the safeguards be needed, it included flow charts and decision trees to assist staff. At the time of our inspection there had never been a need to use this policy.
- The provider had in place a Do Not Attempt Resuscitation policy (DNAR), last reviewed March 2015. The policy informed staff of their roles and responsibilities. The policy stated 'Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR.' The policy also described the provider's stance on any advanced directives and advanced statements the patient may have.

Are surgery services caring?

Good

We rated caring as good.

Compassionate Care

- Duchy Hospital had a privacy and dignity policy that staff were aware of and could refer to, last reviewed September 2013 and due for review. This gave guidance to staff on maintaining privacy and dignity for patients and to provide suitable environments to mitigate the likelihood of issues arising from the delivery of care without due regard to patients privacy and dignity.
- We spoke with seven patients who were all complementary about the staff and their treatment while at the hospital. They spoke of the hard working teams and kind and caring nursing staff.
- We observed staff reassuring patients and taking time to explain procedures to those who were anxious. Staff spoke clearly and slowly ensuring the patient understood. Nursing staff also spent time with patients allowing the patient to talk about any worries.
- The hospital's Patient Led Assessments of the Care Environment (PLACE) results for privacy and dignity were above (96%) the England average (83%).
- The NHS Friends and Family Test (FFT) shows the opinions of NHS patients using the service. The Duchy's FFT scores were similar to the England average across the reporting period (January 16- June 16). Response rates to the test were above the England average of NHS patients. The FFT also showed 100% of patients were likely to recommend the services in all surgical areas apart from, orthopaedics, which scored 93%.
- A chaperone was available to all patients should they request this. A chaperone policy was in place last reviewed December 2014 which noted a chaperone facility was always available. Patients were made aware of chaperones during pre-assessment.

Understanding and involvement of patients and those close to them

- Patients had a named nurse who was responsible for their care and gave them a point of contact during their stay. This ensured a continuity of care and enabled staff to hand over to the next person taking care of the patient.

- Private patient's costs and fees were discussed at the pre-admission visit to enable the patient to make an informed decision about continuing with treatment.
- We saw that discharge planning began at pre-assessment; this was discussed with the patients and their families, and this ensured post-operative support was in place.

Emotional support

- We observed staff talking with patients, answering questions related to their care and engaging them in general conversation to make the stay as normal as possible.
- Assessing of a patients anxiety formed part of the pre-assessment process and was an ongoing assessment and documented in the patients care record.
- Staff also recognised that often family members were more anxious than the patient and would spend time with partners reassuring them and explaining procedures if need be; staff told us sometimes a simple cup of tea helped worried family members.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned to meet patients' needs. The bookings team took time to consider the patients location and times for travel given the rural nature and limited transport options within the county and planned appointments accordingly.
- When adverse weather conditions prevented patients from returning home, staff arranged accommodation with suitable facilities at a nearby hotel. Staff told us about an example where they had taken the necessary equipment needed to the hotel, in order to accommodate a patient safely.
- Patient arrivals were staggered throughout the day to enable staff to manage admissions and to reduce the waiting times for patients.
- When booking patients in for initial assessments, staff would always consider where patients lived in order to plan the timing of the appointment. For example, some patients travelled from the Isles of Scilly and so staff ensured they took into account train, plane and ferry times.

Access and flow

- Individual patient needs were assessed and provided for where possible. For example, some patients were able to come in the night before their operation if they were too ill or frail to travel on the morning of the operation. This was offered to patients regardless of whether they were NHS or private patients.
- If patients had to be cancelled, they were rebooked in a timely manner and a suitable time agreed. All patients who still required procedure were offered another appointment within 28 days.
- Above 90% of patients were admitted for treatment within18 weeks of referral in the reporting period (July 15 to June 16).
- Patient's duration of stay varied dependant on procedure, but the longest length of stay was approximately four days. If patients chose to remain longer they could pay for the service.
- Duchy hospital had 84 cancelled procedures in the reporting period (July 15 to June 16). We looked at the cancelation form and could identify no common themes for these cancellations.

Meeting people's individual needs

- The hospital aimed to ensure it met the needs of different people on the grounds of gender, gender-reassignment, pregnancy and maternity status, race and religion, where possible. Staff told us they would always consider a person's individual needs and do their best to ensure these were accommodated. For example, staff arranged for a patient who was breastfeeding to be able to stay in a room with a sofa, so that her husband could stay overnight, and help with her care and support.
- Staff received training to ensure they could effectively care for patients in vulnerable circumstances, such as those living with dementia. For example, staff ensured that the daughter of patient living with dementia was able to sleep in the patients' room overnight. Food would be provided by staff for patients and relatives without any extra charge.
- A GP liaison role was established at the hospital which provided a central point of contact for general practice

based staff, GPs and practice managers. Consultants would sometimes go out into general practice to deliver education to general practitioners, facilitated by this role.
- Staff told us they would access interpreter services through a language line. This meant staff would telephone the service and the patient would speak to the service who would interpret for staff.
- Patients were satisfied with being able to access food to suit their personal preferences. The Patient Led Assessment of the Care Environment scores for food at Duchy hospital, were higher than the national average.
- Psychological support was available from an external service. Patients having cosmetic surgery would be considered for this service. Patients having bariatric surgery were all offered this service.
- In each room patients were provided with a telephone and internet access and with a TV with remote control. Patients were encouraged to bring in other devices of their own such as tablets and laptops.

Learning from complaints and concerns

- A Ramsay management of patient complaints policy last reviewed March 2016 was accessible to staff, which outlined actions staff should take, should a complaint be made.
- In line with the policy, staff were encouraged to identify and discuss potential complaints with line management, in order to resolve them quickly and at the time the concern was identified. Both clinical and non-clinical staff said they shared information with the relevant line manager or department, if they thought the information might result in a complaint, so that it could be resolved before the patient left the hospital.
- When complaints or concerns were identified patients were given the opportunity to discuss this with the relevant department manager or matron and a meeting was set up at the hospital to enable this.
- In the previous 12 months dated June 2015 to July 2016 the provider received 54 complaints. This is similar to the rate of other independent acute hospitals.
- The registered manager was responsible for ensuring all complaints were acknowledged in writing within two working days from the date the complaint was received. During the inspection we reviewed six complaints and could see this process was followed.
- One complaint was referred to the ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period. Matron confirmed that this complaint was withdrawn by the complainant.
- Some patients reported complaints through the NHS patient advice and liaison service who would contact the hospital to inform them about the complaint.
- Complaints were entered onto an electronic recording system which was also used for the management of incidents. The complaint could then be assigned to the most relevant person and any relevant documentation attached within an electronic record. Human resources personnel would speak with staff where the complaint was non-clinical. However if the complaint was clinical, the hospital matron would initiate this discussion.
- In the complaints reviewed during the inspection we saw that an acknowledgement letter and response took place within the timescales set out in the policy. Further investigations were taken and patients were written to within a set time frame in line with the policy. Matron led investigations into clinical care and would liaise with the relevant staff or departmental manager.
- Staff confirmed learning from complaints was discussed at a variety of meetings which included heads of department, senior management team and the clinical governance committee meetings. The heads of department would decide to share lessons learnt from complaints with wider teams or with individuals, as appropriate. For example, a recent concern was raised relating to noise in corridors. This was shared in the weekly update to staff which they received in an email, or was placed on notice boards and stands on dining tables in the staff dining room.
- Where a complaint involved a consultant's input or care, the hospital manager would contact the consultant and ensure that a response was collated as part of the investigation, in a timely way. We saw this process was followed in all complaints we reviewed. A holding letter was sent to the complainant which outlined a further response would be received within 21 days, during which time, the provider would contact the consultant for their response. If a patient remained unhappy with the response the complaint moved to stage two of the complaints process. The hospital confirmed there were sometimes more than one response letter sent to a patient's, but no complaints in recent years had progressed beyond stage two.

- Information relating to complaints was stored within files electronically or if stored in a paper copy, were kept in filing cabinets, which were locked at night and kept in a locked room in order to protect the confidentiality of those involved.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership / culture of service related to this core service

- The corporate team did not visit the hospital on a regular basis but local leaders were visible. The medical lead for Ramsay visited the hospital for the annual general meeting. The regional director visited the hospital more regularly. Staff spoke positively about leaders within the hospital and the senior management team. The felt they were accessible and were able to approach them or email them, and would get a response.
- Staff felt leaders were visible, approachable and were often seen on the wards. Staff described an open door policy where they could speak with managers when they needed to, and discuss concerns or share ideas.
- Leaders told us they encouraged supportive and appreciative relationships among and with staff. There was a culture of developing staff which was frequently referred to as 'growing your own'. Staff spoke highly about the opportunities leaders within the hospital had provided them, and there were examples of staff who had worked in numerous departments due to ongoing development and career progression.
- Senior leaders attended Ramsay wide training twice a year where they would review new policies, procedures, changes to the regulations and ensure the fit and proper persons and regulatory duties were met. Registered managers had regular Disclosure and Barring Service checks to ensure they met the fit and proper persons regulatory requirements.
- Somestaff we spoke with had worked at the hospital for a significant amount of time and had recommended the hospital as a good place to work, to friends and family.
- Both staff and management said that staff development was encouraged and shared a number of examples where staff were developed and promoted to senior positions more suited to their potential.
- Managers provided a flexible shift system to staff, who could work longer or shorter shifts, based on their individual preferences and personal circumstances.
- Both the hospital and its stakeholders, such as the local clinical commissioning group and the local acute trust, reported positive relationships.

Vision and strategy for this this core service

- There was a vision and strategy for the service which related to being the leading independent provider of services in Cornwall. The aim was to deliver quality care, good patient outcomes and long term profitability, through innovation, attention to detail and recognition of its staff.
- Staff talked about a vision of providing a quality service where the reputation of the hospital and the patient experience was of high importance. However, staff we spoke with were unclear of the strategy for the hospital. Staff were aware the hospital management were keen to develop new services where possible and were kept informed about changes to service provision. However, management reported staff were not as aware of the vision and strategy as they would like but said they aimed to address this through staff forums and other methods of communication.
- Staff spoke about a vision of bringing services closer to the patient's home and to provide services that were accessible to those within the locality. Staff were clear about ways in which they aimed to ensure the local population could access care and treatment at the hospital. They were also proud that the hospital was able to offer services, such as the spinal surgery and cardiac diagnostic and treatment procedures, so that patients did not have to travel further afield or wait longer to receive care.

Governance, risk management and quality measurement

- Whilst there was a clear structure for governance and risk management at the hospital, governance arrangements, audit and risk management processes to monitor quality and safety, were not always effectively implemented or actions monitored. This did not support the delivery of the strategy and good quality care.

Requires improvement

Surgery

- The registered manager maintained overall responsibility for the safety and quality of the service and told us they maintained an overview of audits, incidents and complaints reported onto the electronic incident recording system.
- The senior management team was made up of the Matron, operations manager and finance manager, who reported to the hospital manager. Clinical governance within the hospital was led by the matron, who was responsible ensuring staff adhered to corporate and local policies. The senior management team oversaw all committee groups within the governance structure.
- The Medical Advisory Committee fed into the Corporate Medical Advisory Committee and met quarterly. The registered manager sat on the Medical Advisory Committee and consultants from different specialities attended. The committee met approximately five times a year and was well attended. The committee reviewed new practice, procedures, medicines or equipment in order for this to be signed off in hospital. The Medical Advisory Committee reviewed incidents in order to identify any trends with consultants or concerns with practice, and could escalate concerns to the Ramsay medical director.
- The Clinical Governance Committee met every two months and reported to the Corporate Clinical Governance Committee. The agenda included a review of incidents, reports from clinical committees and professional groups and the Ramsay audit programme. However, we noted that issues and risks identified in the audit programme were not always discussed.
- Quality and safety was also monitored through feedback from patients and by reviewing benchmark data, such as patient reported outcome measures, the National Joint Register and by measuring against local data. However, benchmarking for cosmetic services was not implemented or outcomes monitored.
- Clinical care was not afforded adequate priority on the risk register. The risk register for the hospital contained financial, workplace health and safety, legal and compliance, leadership and management, emergency and disaster response, and sustainability risks but only a small number related to clinical care. The register did not appear comprehensive enough to address current or future risks. The risk register was held centrally which provided a corporate level of access. Departmental managers would monitor their individual risk logs.
- Senior managers confirmed the most significant risks at a hospital level were those that appeared on the hospital's risk register.
- Risk indexes/logs at departmental level identified individual risk assessments, all of which would be signed and dated and could be viewed by staff within the department. For example, moving and handling risks.
- A range of managers and staff attended a daily meeting called a huddle, in which staffing issues, equipment, incidents, complaints and other issues that might affect the day-to-day running of the service were raised and actions discussed.
- Assurance process and governance frameworks were not always effectively implemented or monitored. For example, not all policies and procedures were adhered to, such as the management and investigation of incidents and consent. Duty of candour was not fully implemented and did not follow hospital policy. In addition, a member of staff who had not been adequately trained, carried out root cause analysis investigations into serious incidents. This did not provide adequate assurance about the governance processes, safety and quality of care within the hospital.
- Audit work did not assure the hospital provided effective and safe care at all times. A Ramsay wide audit programme was used within the hospital to measure quality and safety. This audit was examined quarterly at a corporate level. We reviewed information and data contained in the hospital's audit system which related to the previous 12 months prior to the inspection. We found actions were not always identified in audits where results were concerning. It was not always clear from the audit who was responsible for taking actions forward and there was a lack of consistency in managing gaps identified within the audit
- It was clear in our review of patient records, investigations and the audit programme, that the hospital was not managing the deteriorating patient effectively. Systems and processes used to identify patients whose condition was deteriorating, were not implemented and monitored effectively.
- Matron confirmed staff had received training in relation to the Ramsay audit programme approximately 18 months prior to the inspection, but it was not clear whether all staff carrying out the audits had received this training. The Clinical Governance Committee reviewed audit scores, however Matron confirmed that

the overall score was the main focus and not the individual lines of low scores. Therefore, the systematic programme of clinical internal audit, used to monitor quality and systems to identify where actions should be taken, was not used or monitored effectively. This did not provide assurances about the quality and safety of the service.

- Incidents were reviewed at the clinical governance committee and in the clinical heads of department meetings, who would share learning with staff following these meetings. We reviewed meeting minutes and confirmed this process was followed.
- For new services introduced to the hospital, the registered manager confirmed incidents and clinical outcomes would be monitored and services paused if concerns about safety or quality were raised.
- The Medical Advisory Committee oversaw practising privileges, to decide which consultants could practice at the hospital. We reviewed six files for practising privilege arrangements for both NHS and non-NHS staff who worked in a number of hospitals. Out of the six files, all consultants had indemnity in place and only one consultant's appraisal was out of date. However, there was a process in place for administrative staff and the registered manager to ensure the appraisal was received in the 15 month deadline, and we saw evidence of this process being actioned.
- A number of service level agreements were in place some of which were with the local acute trusts such as for pathology, as well as being organised corporately, such as laundry services.
- A new electronic patient record system had been introduced across Ramsay hospitals and was due to be implemented this year at the Duchy hospital. Managers said they would oversee the install of the new system, which would be added to the risk register, at that time.

How people who use the service, the public and staff engaged and involved.

- The hospital recognised long-term service with awards at five, 10, 15 and every onward five year interval. Staff received an additional day's annual leave and vouchers, presented to them by the general manager.
- Staff said that following a stressful time or a hot summer's day, management arranged for an ice cream van to attend the hospital and for all to have ice creams. On other occasions, management brought cakes or donuts for all staff. Staff received a gift and wine at Christmas. A further incentive for staff was the inclusion of the use of a local park and ride system in order to free up the car park. Staff were encouraged to use this scheme and were rewarded with a free lunch for doing so.
- A staff fund was established to hold donations made by patients, following their care and treatment at the hospital. Funds were shared with staff on a pro rata basis, every two years.
- There was a suggestion box in the hospital where staff could give any ideas. Suggestions could be discussed during staff's appraisal the appraisal or with the head of department, or Matron. Further to this, staff were able to send an email to more senior management, and staff confirmed they would get a reply.
- To understand changes and developments at a corporate level, staff received weekly email and a quarterly Ramsay Way magazine. For any local developments or news, staff noticeboards weekly bulletins and notes that were left in the dining room, for example, provided communication with staff.
- A new initiative called 'work out at work 'allowed staff access to health and wellbeing assessments. Staff could try out fitness equipment and have health-related assessments such as body mass index in order to promote well-being. Staff were also given rapid access to diagnostics and physiotherapy services to help them to return to work or to prevent them going off sick. Noticeboards in the hospital also focused on staff well-being. The latest information focused on mental well-being, instigated by a national mental health promotion.
- Staff also had access to support services such as counselling, legal information and a range of benefits which included discount for holidays, goods, health insurance and vouchers. Some staff received health insurance which was linked to the number of hours staff worked all staff could top this up to ensure it included part-time workers. Staff are also offered a flexible leave system whereby they could buy up to next two weeks annual leave or sell a week if they had too much left over at the end of the year.
- Social and team building events were organised periodically such as the annual ball. A barbecue had recently taken place at a local beach restaurant.

- Managers of hospital and staff felt they listened to and tried to accommodate the views of patients, carers and relatives and sought their feedback where possible. The hospital tried to set up patient forums, but reported these had not proven successful.
- The hospital took part in the annual Patient Led Assessment of the Care Environment audit where public service users were invited to review the environment. A number of staff talked about how feedback had been used, from disabled or wheelchair users and how this had been put in place to make improvements to the hospital.
- Patients and families were encouraged to fill-in the Friends and Family Test (FFT), and the discharge paperwork provided a space where feedback could be given to the hospital. The hospital's FFT scores were similar to the England average of NHS patients across the period January 2016 to June 2016. Response rates were above the England average of NHS patients in the same period apart from in June 2016.Feedback could also be provided online through the hospital website, and through patient satisfaction survey.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The hospital had recently commenced new spinal services which the consultant led. As the consultant involved was based outside of the county; in order to meet the local patient needs they had innovated a system whereby the patient would have a scan, the results were sent to the consultant and then an informed telephone conversation with the patient took place. Arrangements were then made for treatment when the consultant was scheduled to work at the hospital. This also helped to provide services to the patients closer to home.
- New services were being introduced into the hospital such as the spinal service, and bariatric services and the cardiac services were being developed.
- Staffing and services had increased over the past ten years and the hospital had grown from employing 105 whole time equivalent staff to 175 in this time frame.
- The hospital had admitted an increasing number of complex patients in the previous 12 months. An orthopaedic geriatrician did not currently have practising privileges at the hospital despite attempts to recruit a specialist orthopaedic consultant who specialised in care of the elderly. However an orthopaedic geriatrician visited the hospital to provide advice to consultants but worked solely in an advisory capacity and did not treat patients.
- To support recruitment and retention, senior management looked at pay structures in order to marry NHS and private employment packages. To encourage new consultants to practice at the hospital they offered flexible consultation bookings instead of block room bookings. For example, booking a consulting room for a small period of time in order to nurture a working relationship with the hospital and patients, rather than having to pay for consulting room for longer periods.
- Staff felt very proud about a number of aspects of the hospital. In particular, they were proud of the standards of hygiene, the atmosphere and teamwork and felt that they always got good feedback from patients. Staff felt innovation or suggestions were encouraged by management who were open and approachable.

Requires improvement

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- All staff that we spoke with had been trained to report incidents via the electronic reporting system. However, some staff told us that it could be difficult to log-on to the system. If they could not access the computer system there was a manual system of recording incidents that could be up-loaded at a later date. This system relied on a manager or another member of staff entering it onto the system. However, this was not included in the hospital policy regarding the reporting of incidents. It was noted in the meeting minutes of the May 2016 Heads of Department meeting that the number of incidents being added to the system was rising.
- Staff were aware of their responsibilities to report incidents and could describe some that had happened in the past.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisations, including the CQC. There had been no externally reported radiation incidents in the last 12 months however on looking through locally investigated incidents it appears that one minor error should have been reported to the CQC but the advice given by the radiation protection advisor (RPA) for the hospital was incorrect. The RPA was employed by a separate organisation.
- In the last 12 months there were 11 incidents in radiology. None were serious and four were due to inadequate referrals.
- Incidents were discussed at local, bi-monthly governance meetings and at the radiation protection committee, which met once a year. This committee was attended by the radiology service manager (RSM), the radiology governance lead and the head of corporate diagnostics. In addition the RSM attended corporate radiology meetings which were held quarterly.
- The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available to staff electronically and in paper format. All staff we spoke with were aware of how to access the information.
- Staff told us they received feedback from incident investigations via a “lessons learnt” newsletter which was distributed every three months. We saw copies of the newsletter in the file where minutes of staff meetings were stored. For more urgent lessons learnt, information was circulated as required.
- Safety alerts, for example about medical devices, medicines or infections, were received by the hospital and communicated to heads of department.

Duty of Candour

- See Surgery section for main findings.

Requires improvement

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- Outpatient, physiotherapy and diagnostic imaging departments were visibly clean and tidy. We saw departmental cleaning records displayed in all departments. These demonstrated that cleaning took place according to a fixed schedule.
- The results of monthly infection control audits showed 100% compliance with infection prevention measures.
- Naso-endoscopes (an instrument used to view the inside of the nose and throat) were used in the main outpatients department. They required careful decontamination which used to take place in the endoscopy department. However, recent problems with endoscopy decontamination equipment meant that this was no longer possible. The outpatient manager had discussed this with the corporate decontamination lead who had arranged for the naso-endoscopes to be decontaminated at a sister hospital in Bodmin. Before leaving the outpatients department, we observed that they were packed in appropriate containers and were sealed and labelled according to infection control guidelines.
- The ultrasound department had a cleaning procedure for intra-cavity probes and all probes were cleaned with the appropriate antiseptic wipes.
- Hand sanitisers were widely available throughout all outpatient departments. We saw staff and visitors using them on a regular basis.
- Personal protective equipment , such as gloves and aprons, was readily available for staff in all clinical areas. The equipment helped to ensure staff safety and reduce risks of cross infection when staff performed procedures.
- Nursing staff and other healthcare workers adhered to the 'bare below the elbow' guidance to allow thorough hand washing and reduce risk of cross infection.
- The hospital's Patient-Led Assessment of the Care Environment (PLACE) scores were the same or better than the England average.
- The hospital had no incidences of clostridium difficile, methicillin-resistant staphylococcus aureus (MRSA) or methicillin-sensitive staphylococcus aureus (MSSA) in the period September 2015 to August 2016.These are all infections that can cause harm to patients.

Environment and equipment

- All items of equipment were labelled with the last service and review date. All had an asset number to allow easy tracking if they needed servicing or maintenance. We saw evidence of the manufacturers completed service reports. We also saw evidence of routine surveys of all X-ray equipment. These were carried out by an outsourced medical physics service.
- The appointed radiation protection adviser was provided through a service level agreement with an acute NHS trust based in London. The same NHS trust provided the laser protection advisor. There was an appointed and trained radiation protection supervisor. Their role was to oversee equipment safety and quality checks, and ionising radiation procedures, in accordance with national guidance and local procedures.
- Signs in the diagnostic imaging department identified when X-rays were being taken and informed people not to enter the room.
- Specialised personal protective equipment was available for use within radiation areas. Staff wore personal radiation dose monitors.
- A small, class four laser was used in two consulting rooms. There was inconsistency in the safety measures to be used before the laser was switched on. The local rules for use of lasers stated that "the door must be kept closed and the laser warning sign must be illuminated". However, there was no warning light above either door. The outpatients manager told us that a temporary warning sign was hung on the door instead.
- We asked to speak to the laser protection supervisor (LPS) who had signed the local rules. We were told that this person was no longer in post and had been replaced by one of the hospital managers. When we spoke to him he told us that he was not the laser protection supervisor. Several other members of staff were also unable to identify the post holder. This meant it was not clear who the LPS was from the staff we spoke to during the inspection. The LPS should be clearly identifiable to staff, as outlined in the hospital's local rules.
- The diagnostic imaging manager and the radiation protection supervisor had produced a quick reference file regarding radiation regulations. This file allows immediate access to relevant information with the additional comprehensive documentation being stored electronically. This improved safety and efficiency.
- Resuscitation equipment for the main outpatients department was stored in a trolley shared with the

adjacent ward. The trolley had several drawers that were sealed with tamper-evident tags. We saw a daily check sheet which recorded the trolley had been checked to ensure equipment was available and in date.

- Outpatients staff were trained in the use of the equipment every six months. However, because they were not responsible for checking the equipment they were unsure where to find specific items. There were no labels on the drawers to guide them. This meant that there may have been delays in finding equipment in an emergency.
- There were risk assessments for the hazardous substances kept in the departments. They accurately described the measures that needed to be taken to reduce the risks. We checked the precautions taken for the liquid nitrogen that was used. All staff were familiar with the safe procedures that needed to be used for use, movement and storage.
- The medical records store was cramped and difficult to work in. Heavy boxes of paper were stored on the floor, posing a manual handling risk.

Medicines

- Medicines in outpatient departments were stored safely. All medicines cupboards were locked and the keys held by the lead nurse on duty. Staff we spoke with knew who held the keys. Fridges were locked and temperatures checked daily and logged, to check medicines were stored at the correct temperature. We checked a random sample of medicines in the outpatient department and in radiology, all of which were in date.
- Local anaesthetic drugs were not always recorded in the patients' records. We looked at records of five patients who had recently had minor operations in the outpatient department. Although the procedure register stated that local anaesthetic had been used, there was no record of the particular drug used, the dose, or who had injected it. Only two of the five patients had additional records with an accurate record of the medication given. This is contrary to current legislation and guidance.
- Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography. These materials were safely stored in the diagnostic imaging department.
- There were no controlled drugs in the departments.
- Staff described how they report medicines errors and the hospital matron explained that she had oversight of all medicines errors. The errors were also reviewed at a corporate level by a pharmacist.
- Prescription stationary was stored securely and their use was logged. The nurses dispensed some medicines required for people to take home from stock from a doctor's prescription. These medicines were supplied in the original manufacturer's packaging and were appropriately labelled.
- A medicine management audit took place every six months; issues arising from the previous two audits had been actioned.

Records

- In all outpatient and imaging areas, we observed patient records were kept in secure areas so the information they contained remained confidential.
- All patients attending the outpatients department had a GP referral letter or their current medical records from a previous appointment or admission.
- The hospital only stored records for patients who had been admitted to the ward. Outpatient records were regarded as the responsibility of individual consultants and were kept by their secretaries, usually at another location. Consultants brought them to the hospital whenever they were holding a clinic. This meant that there was not a complete individual record for each patient. If they were being treated by more than one doctor, important information from another doctor was not available.
- The hospital did not retain copies of letters sent to GPs following an outpatient consultation. This meant that some clinical information may not have been available when needed.
- Existing records of NHS patients who were to be treated at the Duchy Hospital were collected by a hospital porter. They remained at the hospital whilst treatment was carried out. When the patient was discharged an account of the treatment carried out was added to the NHS record before they were returned.
- We were told that it was hospital policy to keep records of any minor procedures that were carried out in the main outpatients department. We looked at five records but only two had complete and correct information such as consent, allergies, previous medical history and medication administered.

- Two other procedures: an injection into a hand and insertion of a grommet had no records at all. The only indication that they had been carried out was a brief entry into the procedure register stating the name of the patient, the procedure and the doctor who had carried it out A fifth set of records, for a punch biopsy of the skin, had no description of the site of the biopsy or the dose of the local anaesthetic used. The hospital used a radiology information system and picture archiving and communication system. This meant patients' radiological images and records were stored securely and access was password protected. This system underwent a recent upgrade and we were informed that all staff received training on the new functionality and that the deployment had gone well.
- The radiology information system, and picture archive and communication systems interfaced well and ensured the patient records and their associated images were rapidly available for comparison and reporting, with rapid access to stored data.
- We reviewed 20 imaging patient records which demonstrated that all necessary information including scanned documents and safety checklists were stored correctly.
- Image transfer to other hospitals and the receipt of images taken elsewhere was via the image exchange portal which all radiology staff were able to access and use.
- We visited the medical records department and found that the doors were secured with a digital lock. The passcode was changed every six months to ensure that no unauthorised person could gain entry.
- The medical records were filed according to the month that a patient was treated, rather than alphabetically or by patient number. If the date of treatment was not known, or if the patient had been admitted more than once, it was difficult to find the record. A member of staff told us that finding previous records was very time consuming, this could lead to a delay if patient records were needed in an emergency.
- Records were stored for the statutory number of years and were then securely destroyed.

Safeguarding

- Adult safeguarding policies were in date and procedures were accessible to staff in all outpatients departments.
- Staff could explain the process to follow if a concern was identified. The hospital had named safeguarding leads and staff could tell us who they were. However, the safeguarding lead was only level 2 safeguarding trained. There was however, further support from the corporate level safeguarding lead who was trained to level five. Female Genital Mutilation was included as part of the safeguarding policy and formed part of staff's safeguarding training,
- Staff completed an on-line, electronic learning training module as part of their mandatory training for safeguarding adults. Training records showed 96% of staff in outpatients departments had received level 2 safeguarding training for vulnerable adults. All staff had completed level one training in safeguarding children.
- The World Health Organisation safety checklist was used before all interventional procedures in the cardiac catheterisation laboratory.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control, information governance and manual handling. Most training took place online and uptake was good.
- Completion rates varied from 95% to 100% of staff in outpatient departments which complied with targets set by the hospital.
- We saw evidence of a detailed, equipment training programme for radiographers and radiologists. Each operator was approved as competent once assessed by the clinical supervisor to use a piece of equipment.

Assessing and responding to patient risk

- There was always a resident medical officer on duty, who was trained in advanced life support. They provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients were transferred to the inpatient ward or to the local acute NHS Trust in line with the emergency transfer policy.
- Staff in outpatients departments were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. They had received training in basic life support, with some staff trained in immediate life support.
- There was a radiation protection advisor and radiation protection supervisor for the hospital. They had been appropriately trained and their roles met the Ionising Radiation (medical Exposure) Regulations.

Requires improvement

Outpatients and diagnostic imaging

- We saw evidence that radiographers, with advice from the radiation protection advisor, carried out risk assessments for all new equipment or procedures.
- There was a programme of radiation dose audit in place in order to review patient doses. Diagnostic reference levels, as required by IR(ME)R, have been set with some locally derived data to better reflect local practice and equipment.
- There were risk assessments in place for all imaging equipment including a risk assessment for access to the mobile scanning vans and use of emergency equipment for these patients.
- There was a pregnancy status check policy in place and the status of all women of child bearing age was checked by radiographers prior to examination. There was also clear signage within the department waiting areas and changing cubicles to ask patients to let staff know if there was a possibility that they were pregnant.
- The World Health Organisation checklist adapted for cardiac procedures was used in the cardiac catheter laboratory. Following each procedure the documentation was scanned into the electronic patient record. Safety checklists described in the National Safety Standards for Invasive Procedures had recently been implemented. This had further enhanced patient safety.

Nursing staffing

- All outpatient departments reported they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner. Our observation of clinical activity confirmed this.
- Consultants could contact the outpatient services at any time requesting an ad hoc clinic. This was agreed if there was an available consulting room and sufficient nursing staff.
- No agency staff had been required in the last year. There was pool of temporary staff who could be called upon to cover staff sickness or annual leave. All had worked for the hospital for more than a year and were familiar with local working practices.

Medical staffing

- The hospital at the time of the inspection employed 133 medical staff working under rules or practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital.
- The hospital completed relevant checks against the Disclosure and Barring Service. The registered manager and Medical Advisory Committee chair liaised appropriately with the General Medical Council and local NHS trusts to check for any concerns and restrictions on practice for individual consultants. The General Medical Council is a public body that maintains the official register of medical practitioners within the United Kingdom.
- There was sufficient consultant staffing to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital outpatient department and administration team.

Major incident awareness and training

- The hospital had a business continuity plan in place for use in the event of disruption caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage, or due to external circumstances beyond the control of the hospital (e.g., bomb threat).
- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. All staff understood their responsibilities if there was a fire within the building.

Are outpatients and diagnostic imaging services effective?

We did note rate effective.

Evidence-based care and treatment

- Staff told us they were able to access national and local guidelines through information folders held in each department and also via Royal College internet sites. Staff were updated about changes to policies and guidelines through a clinical update newsletter that was emailed to staff on a monthly basis.
- Staff confirmed managers shared clinical governance information and changes to policies, procedures and guidance with them.
- Imaging staff had a sound knowledge of Ionising Radiation (Medical Exposure) Regulations 2000 relevant to their area.

Requires improvement

Outpatients and diagnostic imaging

- Local diagnostic reference levels had been established for some examinations and were routinely reviewed by the medical physics service. There was on-going dose audit work to increase the amount of locally derived data.
- Radiographers checked all referrals to ensure patients were booked for the correct imaging tests and the requesting information was fully completed. Imaging investigations did not take place if the correct patient information was missing.
- Nurses in the outpatient department ensured that protocols used in the pre-admission clinic followed guidelines from the National Institute for Health and Care Excellence (NICE). Sleep apnoea assessment had been introduced following research published in the British Journal of Anaesthetics.

Pain relief

- In outpatients and the cardiac catheter laboratory, staff discussed options for pain relief with the patient during their consultation and before any procedures were performed.
- Patients received written advice on any pain relief medicines they may need to use at home following outpatient procedures.

Patient outcomes

- Nurses in the pre-admission clinic took part in six-monthly audits of the policy for prevention and management of venous thromboembolism (VTE). Results showed good compliance, ranging from 95% to 100%.
- Radiology audits included clinical evaluation of images, post examination documentation, non-medical referrals and clinical referrals. We looked at the results of the audits which showed that good practice was being carried out.
- There was a corporate audit programme which some staff told us they found it difficult to use. It included topics such as pre-admission assessment, physiotherapy clinical effectiveness and national radiation regulations. Audits only required ten patients' records to be audited which, in some cases, was a small sample size, out of a total of over 12 thousand initial outpatient attendances between July 2015 and June 2016. June. For example, an audit to look at the completion of pre-admission and discharge records for ten patients was carried out twice in a year.. This meant that the results may not have been typical of normal activity.
- Patients were offered opportunities to participate in data collection to measure outcomes of treatment. All patients who were booked for joint replacement were asked for consent to be registered on the National Joint Registry, which monitors infection and revision rates. We saw in medical records that we reviewed, patients had consented to participate in the register which ensured their care and joint replacements were monitored nationally.

Competent staff

- Managers compiled a detailed induction pack to ensure new staff had the knowledge and skills required to work in each department. One nurse in the main outpatient department told us that she had not been given this when she started and had asked more experienced staff for help. However, other staff confirmed the induction pack had been used since the arrival of a new manager.
- There were competency frameworks for clinical and administration staff in each department. Outpatient competencies included patient advocacy, assisting with clinical procedures and cardiac testing.
- We were provided with documentation to confirm 90% of clinical and support staff had received an annual appraisal.
- Nursing staff, radiographers, healthcare assistants and administrators from each speciality were offered training opportunities to develop professionally and gain the latest skills and knowledge relevant to their post.
- There were a number of corporately trained, non-medical referrers that were entitled to request imaging and we were shown training records and clear scopes of practice for these individuals.
- Nurses were aware of the need to revalidate their professional registration. The date when this was due had been entered on the e-rostering system to ensure that nurses did not work unless their registration was current.
- Practicing privileges is authority granted to consultants by a hospital governing board to allow them to provide patient care and treatment within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were regularly

reviewed. The hospital's Medical Advisory Committee followed a process to ensure all consultants who had practising privileges had the relevant competencies and skills to undertake the treatment they were performing at the hospital. This included the review of competencies, outcomes, appraisal and revalidation.
- Patients told us they felt staff were appropriately trained and competent to provide the care they needed.

Multidisciplinary working

- We observed good collaborative working and communication amongst staff in all departments. Staff reported they worked well as a team.
- There was evidence of effective multidisciplinary working. We saw assessment protocols containing agreed pathways for the involvement of anaesthetists and clinical nurse specialists.
- The diagnostic imaging manager and their staff had a good working relationship with referrers and were able to challenge requests that may have been unjustified.
- Radiographers told us that there was always a radiologist available for advice relating to imaging requests and unusual or urgent findings.
- We were told there was a good link with the local NHS trust radiology department.

Seven-day services

- On the whole outpatient services ran from Monday to Friday and from 8am until 8pm. There were occasional Saturday clinics.
- The diagnostic imaging department provided an on-call service available at the weekend.

Access to information

- Staff we spoke with reported timely access to blood test results and diagnostic imaging reports. This enabled prompt discussion with the patient regarding the findings and ensuing treatment plan.
- X-rays were available electronically for consultants to view in the clinic.
- Staff accessed radiology images through the picture archiving and communication system. For images acquired off-site, the image exchange portal and other local image gateways were utilised. All staff knew how to access diagnostic images.
- Consultants dictated clinic letters. They were typed by their private secretaries and were then sent to the patient's GP. However, copies of the letters were not retained by the hospital, meaning that some clinical information may not have been available when needed.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment. Medical staff we spoke with confirmed the transfer methods used and understood the required security aspects of data transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Well-informed written consent was obtained for procedures in the cardiac catheter laboratory.
- We could not assess written consent for outpatient procedures as most outpatient records were kept by individual consultants. We were told that consent forms were available for invasive procedures such as insertion of grommets or removal of moles. However, they were contained in the outpatient notes which were kept by the consultants, not by the hospital.
- Verbal consent was given for X-rays and physiotherapy treatment.
- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in mandatory safeguarding training. Staff that we spoke with demonstrated a good understanding about their role with regard to the Mental Capacity Act.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- During our inspection we saw many examples of patients being treated with compassion, dignity and respect. Staff introduced themselves by name and explained what was going to happen next. Receptionists were smiling and helpful and greeting people with a cheerful "How can I help?"
- There was sufficient space at reception desks to ensure that people were not overheard when giving confidential information.

Requires improvement

Outpatients and diagnostic imaging

- Without exception, people that we spoke with praised the staff for their kindness. One patient said "They are lovely here. They really look after you".
- Another told us that the care they had received exceeded their expectations. We were told that "The nurses never hurry you and they always ask if you are happy."
- The hospital took part in the NHS Friends and Family Test, 98% of outpatients said that they would recommend the hospital.
- Reviews from the NHS Choices website were positive. One patient wrote "From the moment of arriving at reception you are treated with outstanding care, consideration and kindness as a patient at this hospital".
- We often observed staff approaching people who looked lost and asking if they needed help. Information was given slowly and carefully so that it was easy to follow.
- We saw a member of staff crouching down to speak to a patient in a wheelchair so that she was more easily understood.
- We saw that staff took all possible steps to promote patients' dignity and that their privacy was a priority. We observed staff ensuring doors were closed and curtains pulled during consultations and procedures.
- When people experienced pain or physical discomfort staff responded in a compassionate, timely and appropriate way. A patient who had recently had an investigation in the cardiac catheter laboratory told us that he had started to feel pain during the procedure. He told us that the staff's response was very caring. They paused the investigation in order to administer pain relief. They did not recommence until the patient was comfortable and happy to proceed.

Understanding and involvement of patients and those close to them

- Patients received relevant information, both verbal and written, to make informed decisions about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns.
- All staff wore name badges which clearly stated their name and role. This helped patients to understand who was looking after them.
- Staff ensured people who used the service and those close to them were able to find further information or ask questions about their care and treatment. Nurses in the cardiac catheter laboratory phoned patients a few days before the procedure was due to take place. They described what would happen before and during the procedure and gave patients the opportunity to ask questions. A patient that we spoke with said that he found this very reassuring.
- Any patient who had undergone an invasive outpatient procedure was telephoned by a nurse 24 hours later to ensure that all was well.
- Relationships between people who used the service and those close to them were evident. One nurse told us about an elderly patient who had confided that she was worried about driving home in the dark. The nurse phoned the patient later that evening to make sure that she had arrived home safely.
- Staff in the main outpatients department told us that they would keep the department open after hours if patients required it.

Emotional support

- During our visit we observed staff giving reassurance to patients and their relatives. Support and encouragement was given by ensuring that people always had up-to-date information.
- One patient told us that the doctor's explanation of her condition was the best she had ever had. She now understood what was happening and what could be done about it.
- One nurse told us about a patient's relative who was looking worried in the waiting room. The nurse took her to a quiet room so that they could talk. The relative described her concerns about a long-term health condition, unrelated to the current hospital visit. The nurse was able to give her information about an advice line and support networks. During a subsequent appointment the relative reported that she had contacted the advice line, had been given a lot of help and was now much less worried.
- Physiotherapists supported patients to manage their own health, care and wellbeing and to maximise their independence. Patients and their families were invited to a comprehensive pre-admission assessment prior to surgery so that physiotherapist could assess their mobility and discuss their home circumstances. Advice was given about adjustments that might need to be made to the home and equipment to maximise independence was ordered in advance.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of patients. Outpatient clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange ad hoc appointments to meet patient needs.
- The hospital was a provider of Choose and Book which is an electronic booking software application for the NHS in England. It allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- Clinics were held Monday to Friday, 8am to 8pm, with occasional outpatient clinics held at weekends to meet patients' needs.
- The environment in outpatient departments was comfortable and patient centred. There was free parking available and the departments were clearly signposted.
- The diagnostic imaging department provided same day X-ray services for outpatients and the wards.

Access and flow

- Patients told us it was always possible to make an appointment at a time to suit them.
- For NHS patients waiting time targets were for 95% of new patients to be offered an appointment and treatment within 18 weeks of referral to the hospital. The Duchy hospital had consistently exceeded this target during the year ending July 2016.
- All plain X-ray films were reported within two working days with no more than a seven day wait for more complex images.
- Same day X-rays were available for outpatients as required. More complex imaging such as ultrasound or MRI were available within a week.
- On the first day of our inspection, we waited at the outpatient reception desk for 10 minutes, because there was no receptionist present. There was no information at the desk to help people contact a member of staff. We saw from minutes of departmental meetings that the manager had identified this as a problem and was working with staff to improve availability.
- All clinics and outpatient services were running to time during our inspection. Staff told us that if delays did occur, they would tell patients as they arrived and tell them how long they were likely to have to wait.
- The number of patients who did not attend appointments were not monitored. However, administration staff followed up every patient, including NHS patients, who did not attend on the day of the appointment and for a number of days afterwards. Patients were also sent a letter to ask them to contact the department.

Meeting people's individual needs

- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. For example, arrangements were in place for wheelchair access.
- The most recent Patient Led Assessment of the Care Environment (PLACE) awarded a score of 96% for disability facilities. This compared well with the national average of 81%.
- Records showed that all staff had received training in caring for people living with dementia and learning disabilities. They told us that they would help these groups of people by arranging for one of their carers to come with them to appointments. Extra time would be planned into the clinic.
- The most recent PLACE score was 97% for care of people living with dementia. This compared well with the national average of 80%.
- If patients needed additional support in the home the physiotherapy department kept a comprehensive directory to help patients select a domiciliary care agency.
- To reduce the number of visits made to the hospital, the staff organised appointments to ensure that additional procedures such as X-rays or scans took place on the same day as the patient's outpatient appointment.
- When making appointments staff would always consider where patients lived in order to plan the timing of the appointment. For example, some patients travelled from the Isles of Scilly and so staff ensured they took into account train, plane and ferry times.

Requires improvement

Outpatients and diagnostic imaging

- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.
- There was sufficient seating in the waiting areas, with access to hot and cold drinks and magazines. Toilets were easily accessible. There were parking spaces for patients with mobility difficulties. There was always at least one available throughout our inspection.
- All written information, including pre-appointment information and signs were in English. These were not available in other formats such as other languages, pictorial or braille or in large print. Staff told us there were rarely patients whose first language was not English. However, if requested, appointment letters could be translated into other languages. We were shown examples of letters in Polish and Romanian. There were policies for accessing translation services and appointment staff considered those when arranging the length of patient appointments. There was an induction loop at the outpatient reception area to assist patients with hearing difficulties.
- Translation services were requested at the point of booking appointments.

Learning from complaints and concerns

- Information on how to raise concerns or make a complaint was visible in the waiting area of the main outpatient department and imaging department but not in physiotherapy. Staff understood what to do if a patient wanted to make a complaint.
- If the complaint could not be resolved informally a full investigation would take place. We saw that responses to complaints took place according to agreed timeframes. Letters to complainants were courteous and informative.
- There were 13 complaints about outpatient departments for the year ending June 2016. Their nature was varied with no particular themes.
- Complaints were discussed at clinical governance meetings and a "Learning from complaints" newsletter was sent to all departments every three months.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as good.

Leadership / culture of service

- Managers in all outpatient departments had clinical roles and were easily accessible. Staff reported good support, guidance and leadership from their managers.
- The executive team encouraged an open and transparent culture. Staff told us that there was an 'open door' policy. One nurse told us "There are no barriers here. I can walk in and talk to the general manager if I feel the need to".
- Staff were positive about their experience of working at the hospital. Several clinical staff told us that they had "the time to care" and to deliver high standards of diagnosis and treatment.
- All staff said they felt listened to and respected. They felt they could raise concerns and they would be investigated if necessary.
- Hospital staff told us that consultants were supportive and advice could be sought when needed.

Vision and strategy for this core service

- There was no specific vision or strategy for outpatients and diagnostic imaging, other than that reflected in the surgery section. However, all staff expressed a commitment to providing high quality and compassionate care for patients in an effective and efficient manner.
- Departmental managers were able to describe their vision for the future of their departments. These matched those described to us by the general manager which was to develop the ability to undertake more complex investigations and treatments.

Governance, risk management and quality measurement for this core service

See the surgery section for main findings

- There was a defined governance and quality reporting structure in the hospital and staff described this to us. Departments held their own team meetings, in which information was fed back from hospital clinical governance meetings and heads of department meetings. Departmental meetings discussed learning from incidents, safety and quality issues and improvements that needed to be made.
- Outpatient departments did not have their own detailed risk register. Each had a risk log that fed into the hospital risk register. Departmental managers were familiar with these risks and the actions required to reduce them.

Requires improvement

Outpatients and diagnostic imaging

- The diagnostic imaging manager attended meetings of the corporate radiation protection committee, which addressed compliance with radiation regulations, sharing of best practice and standardisation of policies and procedures.
- Staff informed us that since the appointment of a corporate radiology governance lead that there had been improvements in specialist clinical governance both locally and across the corporate group. For example, a new high dose imaging technique had recently been proposed locally. Following consultation with the radiation protection advisor and the governance lead it had been decided that the technique was not appropriate within existing facilities.
- The governance lead was described as being approachable, responsive and sensible in their approach to work carried out within the department.
- National Safety Standards for Invasive Procedures had recently been introduced in the cardiac catheter laboratory. However, its introduction in the main outpatient department had been delayed as some invasive procedures were carried out in consulting rooms without a nurse being present. The outpatient manager was working with the executive team to change this.
- There was a morning 'huddle' held on a daily basis. This was an informal meeting held at the start of each working day where the heads of department came together to discuss potential issues for the day. Any immediate changes that needed to be made were conveyed to outpatients staff which made them feel more involved with the hospital as a whole.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients, by the Friends and Family Test. The hospital provided data for the hospital which was not specific to outpatients and is reflected in the surgery section.
- Regular team building exercises were encouraged and there were numerous examples of motivational initiatives for staff. For example, free lunches were provided for staff who used the park and ride and not the hospital car park. There were free ice creams in the summer from a local ice cream company, a summer ball that was paid for by management and Christmas presents for all staff.

Innovation, improvement and sustainability

- There were regular one to one meetings between departmental managers and the matron in order to assess future demand for services and consequent staffing requirements. This helped to ensure sustainable staffing processes.
- The outpatients manager had recently changed daily wound dressing clinics from the morning to quieter afternoon periods. This had improved patient satisfaction and also meant that there were more nurses available in the mornings to assist with more complex procedures.

Outstanding practice and areas for improvement

Outstanding practice

- Individual patients' needs were assessed and provided for where possible. For example, some patients were able to come in the night before their operation if they were too ill or frail to travel on the morning of the operation. This was offered to patients regardless of whether they were NHS or private patients.

Areas for improvement

Action the provider MUST take to improve

- Have a complete and accurate systematic programme of clinical and internal auditing which can be used to monitor quality systems to identify what actions should be taken.
- Ensure emergency medicines must be stored securely and be readily available such as anaphylaxis kits on resuscitation trolleys.
- Ensure definitive clarity in relation to the anaesthetic rota after the first 24 hours following surgery.
- Make sure patient clinical records for monitoring of the deteriorating patient and the temperature of patients under anaesthesia are recorded, calculated and acted upon as per hospital policy.
- Have a coordinated response system for responding to medical emergencies within the hospital.
- Ensure audits are completed to ensure an effective service was being provided, in line with best practice, evidence-based guidelines and standards, to include audits of cosmetic surgery.
- Ensure second stage consent is gained and systems are put in place to ensure compliance.
- Be assured management and investigation of incidents policies are being followed and ensure incidents are investigated and recorded effectively by trained staff.
- Ensure duty of candour is followed and appropriate records are taken and stored within the patient files.

Action the provider SHOULD take to improve

- Maintain a risk register which provides adequate assessment and overview of clinical risks within the hospital departments, and be comprehensive enough to address current or future risks.
- Ensure staff are up to date with mandatory training.
- Ensure appraisal levels are achieved so that employee performance and productivity, as well as employee developmental needs are met.
- Make provision to ensure the onsite safeguarding lead is trained to level 3 safeguarding.
- Ensure a proportionate number of samples are taken for audit to reflect the number of service users.

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 (1)(2)(a)(b)(c) • Records maintained of the deteriorating patient early warning scores (EWS) had been audited and shortfalls found. Corrective actions had not been sufficient. • Some audits were not completed to ensure an effective service was being provided, or was in line with best practice. This included audits of VTE, anaesthetics, the deteriorating patient and cosmetic surgery. • The incident recording, management and investigation of incidents needs to be accurate so that lessons are learned and trends identified in order to ensure the safety of the service. • Medical records generated by staff holding practising privileges were not always available to staff (or other providers) who may be required to provide care or treatment to the patient • We could not assess written consent for outpatient procedures as most outpatient records were kept by individual consultants. • We were told that consent forms were available for invasive procedures. However, they were contained in the outpatient notes which were kept by the consultants, not by the hospital.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) • The Provider must ensure definitive clarity in relation to the anaesthetic rota after the first 24 hours following surgery.

This section is primarily information for the provider

Requirement notices

- The provider must have in place a coordinated response system for responding to medical emergencies within the hospital.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (2) (g) • Administration of local anaesthetic drugs in the outpatients department was not recorded in line with current legislation and guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care (3) (d) • The provider must ensure second stage consent is gained and documented.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour (a) • The provider must ensure it acts in line with the provider's policy: 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.