Peninsula NHS Treatment Centre

Quality Report

20 Brest Road
Plymouth International Business Park
Plymouth
Devon
PL65XP
Tel: 01752 506070
Website: www.peninsulatreatmentcentre.nhs.uk/

Date of inspection visit: 13 and 14 July 2016
Date of publication: 20/10/2016

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Peninsula NHS Treatment Centre is an independent hospital and part of Care UK Limited. At the time of our inspection it provided care and treatment to NHS patients, with no privately funded work undertaken.

The hospital provided surgery, and outpatient and diagnostic services. There were no services provided to persons under the age of eighteen. Day case and inpatient surgery specialities included major and minor orthopaedics, ears nose and throat, and general surgery. Ophthalmology surgery was located on site but outsourced to an external provider (obtaining services by contract from an outside supplier). There were 28 inpatient beds and 12 patient bays including four patient treatment chairs. There were two operating theatres. There was one procedure room, and there was one pre and post anaesthetic care unit with five recovery bays.

The outpatient department provided a service for patients before and after surgery. No patients were seen in outpatients who were not on the surgery pathway. Diagnostic services included plain film x-ray only. There was a physiotherapy service for inpatients.

All treatment was consultant led. All consultants were employed on either substantive or bank contracts. The senior leadership team included the hospital director, the medical director, and the head of nursing and clinical services manager, and the regional finance manager.

We carried out a comprehensive announced inspection of Peninsula NHS Treatment centre on 13 and 14 July 2016, and an unannounced inspection on the evening of 20 July 2016. We inspected and reported on two core services: the surgery service and the outpatients and diagnostic imaging service.

The overall rating for the Peninsula NHS Treatment Centre was outstanding. We rated both core services as good for being safe, effective and responsive. We rated both services as outstanding for being caring and well-led. Our key findings were as follows:

Are services safe?

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

We rated safety overall as good:

- All staff we spoke with understood the importance of reporting incidents and were confident in the investigation and learning from incidents that extended across all the departments. All staff we spoke with understood the duty of candour principles. The governance management team monitored all incidents and clearly understood the requirements under this legislation.
- The ward manager was the safeguarding lead for adults and for children and this individual was trained to level 4. Staff demonstrated a clear understanding of their responsibilities to recognise and act upon safeguarding concerns.
- All areas of the hospital were visibly clean and there were clear systems in place to ensure high risk areas were regularly cleaned. There had been no incidences of hospital acquired infections during the reporting period of April 2015 to March 2016. Staff were observed to consistently use effective infection prevention and control techniques.
- All patients were admitted under the care of a named consultant who reviewed their cases daily. Out of hours patients were cared for by the resident medical officer (RMO) who contacted consultants when required. The RMOs were employed by an agency and their suitability was closely monitored by the anaesthetists and medical director.
- There were safe staffing levels on the ward, in theatres and in outpatient services. Staffing models were based on nationally recognised staffing tools.
- We saw that all members of the clinical teams were involved in clinical decision making and worked closely together to ensure thorough and timely handover of patients. Policies and procedures were in place for the safe transfer and escalation of patients to the local acute NHS hospital where necessary.

Summary of findings

However:

- Out of date medicines were found in one consulting room and in the day surgery unit. Some medicines were pre-prepared and left unattended in the anaesthetic room, this was not included in the hospital's risk assessment.
- The flooring in consulting rooms was non-compliant with guidelines for infection control and had not been risk assessed.
- The humidity levels of theatres were not maintained at an appropriate level which resulted in an increased risk of fire if flammable materials were used during surgery.

Are services effective?

By effective, we mean people's care, treatment and support achieves good outcomes, promotes a good quality of life, and is based on the best-available evidence.

We rated services overall as good for effective:

- Services at this hospital were effective. Evidence based guidance was used to plan and provide care and treatment to help improve patient outcomes. The hospital participated in national Patient Reported Outcome Measures (PROMS) for knee and hip arthroplasty and groin hernias The PROM's between April 2014 and March 2015 were within the expected range of the England average.
- There were ten unplanned readmissions to surgery within 29 days of discharge between April 2015 and March 2016. This was good compared to other independent healthcare providers who have provided data to the CQC. There were no cases of unplanned returns to the operating theatre in the same reporting period.
- There were nine unplanned transfers of inpatients to other hospitals between April 2015 and March 2016, this is higher than average compared to other independent healthcare providers who have provided data to the CQC.
- All consultants were employed on substantive or bank contracts. Revalidation and appraisal of consultants was completed by the Care UK group and the hospital was 100% compliant.
- All policies originated as corporate documents through the Care UK group and were then modified and agreed by the senior management team to meet local needs.
- Staff acted within the legal framework to obtain consent for patient treatment. Staff were rarely required to implement the mental capacity act and reported any concerns to senior staff when issues arose.

Are services caring?

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

We rated the service at this hospital as outstanding for caring:

- There was an embedded patient centred culture evident in all departments throughout the hospital, and all staff demonstrated genuine compassion for patients and their families.
- Relationships between staff, patients and those close to them were caring and supportive. Teams encouraged patients to be active partners in care and patients felt informed and involved in decisions about their care.
- Leaders empowered staff to promote caring and collaborative relationships with patients.
- Staff took the time to recognise and respect people's cultural, social and religious needs, any preferences were reflected in how their care was delivered.
- Staff provided emotional support to patients, identifying anxieties and responding to ensure the patient was at ease.
- Feedback from patients was overwhelmingly positive about staff and the service they received which they described as exceeding their expectations. Response rates for the friends and families test were above average at 74% and scores during October 2015 to March 2016 indicated an average of 99% of patients would recommend the hospital.
- Twenty five patients reported feedback to their local Healthwatch regarding the care at the hospital. Twenty three of these responses were highly complimentary.

Are services responsive?

Summary of findings

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

We rated responsiveness overall as good:

- Patients experienced a seamless flow throughout their patient journey with many patients not identifying a difference between their preassessment, surgery, and postoperative care.
- The service at the hospital was responsive. The service worked in partnership with the local acute NHS trust to reduce waiting lists and ensure that patients were treated in a timely fashion. Most patients were seen within six weeks of their referral.
- Complaints were handled promptly and sensitively and learning was shared across the organisation. Feedback received from patients was used to improve the quality of service delivery.
- The service aimed to meet the individual needs of patients by offering a choice of appointment times and dates and offering longer appointments where necessary for patients with additional needs such as learning disability, dementia or sensory loss. Carers were encouraged to be actively involved in care.
- The multidisciplinary team made exceptional effort to accommodate the cultural needs of patients, such as single sex room, all female staff teams for the duration of patients admission, specific dietary requirements.
- The hospital used exclusion criteria to ensure that patients accepted for treatment could be safely managed within their existing facilities.
- Consultants were available on call 24 hours daily to respond to emergencies.

Are services well-led?

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

We rated well-led overall as outstanding:

- There was a clear vision and strategy for the hospital which included challenging but achievable objectives. There was a strong collaborative relationship with the local acute trust which resulted in improved care outcomes for patients. All staff were engaged with the values and vision of the hospital.
- The focus on patient centred care was evident at all levels of the organisation and throughout the patients journey.
- Governance systems were robust. Senior staff understood the key risk management issues. Live risk registers were maintained and reviewed regularly. Performance against key performance indicators was discussed at the monthly governance meetings. Current and future risks were actively managed using a thorough process.
- All staff throughout the hospital were actively encouraged to attend monthly 'governance days' when no clinical work other than inpatient care was undertaken. This had embedded a strong understanding of the relevance of governance within hospital teams.
- There was a comprehensive system of audit in place to measure quality. These audits formed an integral part of a continuous learning process. Clear action plans were put in place if non-compliance was identified and learning was shared.
- There was no medical advisory committee. However, the purpose of a medical advisory committee was met by several forums at corporate and local level. The hospital did not grant practising privileges.
- Compliance with the 'fit and proper persons' requirements of Regulation 5 of the Health and Social Care Act were undertaken at corporate level by Care UK. This included an enhanced level of DBS check for the registered manager.
- There was a strong leadership team that were well known and respected by all staff. Staff at every level of the organisation including the night shift told us information was always cascaded to keep them well informed.
- Staff were empowered to raise concerns and make changes to improve services. All staff were proud to work for the organisation and described it as a 'family'.

Our key findings were as follows:

Summary of findings

- Safety was of a high standard. Staff were encouraged to report incidents and these were thoroughly investigated and learning shared across the organisation.
- Staff understood their responsibilities to identify and report safeguarding concerns and were trained to do this.
- The hospital was clean and staff adhered to good infection control practice.
- Comprehensive risk assessments were completed and audited to ensure harm free care for patients.
- Equipment was well maintained.
- Records were accurate and complete.
- There was adequate staffing and staff were well trained.
- The multidisciplinary team worked very well together for the benefit of patients.
- Patient's needs for nutrition and hydration were met.
- Patient outcomes were within expected ranges and were monitored closely. The hospital submitted data for the National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMs). Between April 2015 and March 2016 there were no inpatient deaths.
- Evidence based guidelines were used to provide care.
- All treatment was consultant led with consultant on-call cover 24 hours daily. Diagnostic imaging and physiotherapy was available to inpatients seven days per week.
- Patients were consistently positive in their feedback about their experiences of care.
- Patients described themselves as 'partners in care' and staff ensured patients understood their treatment at every stage.
- There was an embedded patient centred culture, and all staff demonstrated genuine compassion for patients and their families in all interactions we observed.
- Staff provided emotional support to patients, it was embedded in staff practice to value and identify emotional and social needs of patients.
- Teams made exceptional effort to meet the cultural needs of patients
- The hospital was meeting its referral targets.
- Patients were offered a choice of appointments to suit them; treatment was only cancelled or delayed when necessary.
- The service was responsive to the needs of patients with learning disabilities.
- A choice of food options was available to patients that accommodated cultural requirements.
- Feedback from people who used the service was actively sought and used to make improvements.
- Clear governance arrangements were in place and risks were identified and managed.
- The quality of the service was monitored through an extensive audit programme.
- Feedback from staff was overwhelmingly positive about the leadership from department and senior managers. Staff at all levels said information was always cascaded to keep them well informed.
- The senior management team were highly visible and supportive.
- Staff were extremely proud of the hospital as a place to work. Staff spoke highly of the open culture where they were encouraged and empowered to make improvements and develop their potential.

We saw several areas of outstanding practice including:

- Cleanliness of the outpatient, diagnostic imaging and physiotherapy departments was of a high standard, with facilities scoring 100% compliance against cleaning standards.
- The multidisciplinary team working was excellent across all departments and all staff roles. The strong collaboration and support provided was evident during our inspection.
- Patients consistently described feeling highly satisfied with the care they received and we observed this caring in practice. The multidisciplinary team ensured that the totality of patients' needs was addressed.
- Teams made exceptional effort to accommodate the cultural needs of patients such as single sex accommodation, dietary requirements, all-female staff teams for the duration of patient stays.

Summary of findings

- The senior management team were visible, approachable and supportive to staff. They encouraged and motivated staff, and embraced innovation.
- Comprehensive risk assessments were used to assess and respond to patient risks, these were recorded clearly on the electronic patient record.
- The extensive audit programme allowed early identification of areas for improvement, action plans were put in place as a result of any non-compliance.
- Staff were fulfilled by the culture in their working environment. They were extremely proud of the organisation and regardless of their role or level of patient contact had the patient care at the centre of everything they did.
- There were clear governance arrangements which allowed the hospital to work in line with best practice and deliver high quality care

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

- Ensure an effective system is in place to verify that all medicines are in date and checked regularly.
- Ensure that the health care risk assessment for pre prepared medication within the anaesthetic room also includes the risk for leaving drawn up medicines unattended in the anaesthetic room, in line with the Royal College of Anaesthetics guidance.
- Ensure that non-compliant flooring in the consulting rooms have been risk assessed.
- Ensure the humidity of the theatres is maintained at an appropriate level.
- Consider displaying the harm-free care NHS safety thermometer results on the ward in line with best practice.
- Consider the accuracy of the process in theatre for recording the completion of the World Health Organisation safe surgery checklist, specifically the potential for errors when inputting the information retrospectively following the check.
- Consider increasing the size of the signs to the ophthalmic clinic.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Outstanding** ☆	Surgery services at Peninsula NHS Treatment Centre were rated to be outstanding overall. We found: • There were clear processes in place to ensure the safety of patients. Incidents were reported and investigated and as a result action was taken and learning shared. • All areas of the hospital were visibly clean to a high standard; staff demonstrated good infection control practice to reduce the risk of infection. • Comprehensive risk assessments were completed for patients and their application was audited to ensure harm free care and the ability to assess and respond in a timely way to patient risk. • Equipment was well maintained. Staff received training when new equipment arrived to ensure they were competent in its use. • The electronic patient record allowed for clear, complete and accurate records to be maintained for the patient throughout their pathway. • Staff had appropriate training and when spoken with had good knowledge. • There was a resuscitation team and equipment was readily available to respond to an emergency situation. Processes were in place to transfer patients to the local acute trust. • Nursing and surgical staffing was reviewed regularly in line with best practice guidance and safe staffing levels were observed. • Evidence based guidance was used to plan and provide care and treatment to help improve patient outcomes. Patient outcomes were regularly monitored. • Pain relief, nutritional and hydration needs were all assessed and effectively managed. • Staff were competent and the multidisciplinary team working was excellent throughout the departments and professions. • Staff obtained both written and verbal patient consent throughout the patient pathway.

Summary of findings

- Consistent positive feedback was provided by patients who demonstrated high levels of satisfaction of the outstanding care which was being provided.
- Care was person-centred and staff were both compassionate and professional. Patients were kept involved with their care and staff ensured their full understanding.
- Exceptional effort was made by multidisciplinary teams to accommodate the specific cultural needs of patients during their inpatient stay.
- Emotional support was provided to patients. Staff were observed identifying anxious patients and putting them at ease.
- The service was responsive to and accommodated patients' needs, and where possible enabled patients to access care at a time that suited them.
- The leadership, management and governance of the hospital assured the delivery of high-quality person-centred care.
- There were clear governance arrangements in place which reflected best practice and were managed proactively.
- All staff were encouraged to attend the monthly quality governance meetings and were actively engaged in the hospital's governance processes.
- Risks were identified and managed. The quality of the service was monitored through an extensive audit programme.
- The senior management team were visible, approachable and supportive, encouraging an open and fair culture.
- There were high levels of staff satisfaction across all equality groups. Staff were extremely proud of the hospital as a place to work and spoke highly of the culture.
- Feedback from people who use the service was actively sought and used to make improvements.

However:

- Out of date medicines were found in the ophthalmology trolley in the day surgery unit.
- Medicines were pre-prepared and left unattended in the anaesthetic room, this was not included in the hospital's risk assessment.

Summary of findings

- The humidity levels of theatres were not maintained at an appropriate level.

Outpatients and diagnostic imaging

Outstanding ☆

Outpatient and diagnostic services at Peninsula NHS Treatment Centre were rated as outstanding overall. We found:

- There was a strong culture of incident reporting, with no serious incidents reported in the last year,
- The department was clean with good infection prevention controls in place.
- There was a good understanding of safeguarding by staff that were appropriately trained and could describe how to escalate any concerns.
- The use of best practice was evident throughout the outpatients and diagnostic imaging department. The hospital used national surveys to capture patient outcomes.
- Multidisciplinary team working was evident throughout the department and diagnostic imaging and physiotherapy was available to inpatients seven days per week.
- Staff demonstrated an understanding of consent and decision making requirements of legislation and guidance.
- Care was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance. There was an embedded patient centred culture, and staff demonstrated genuine compassion for patients and their families.
- The outpatients team identified the cultural needs of patients and their carers
- Consistent positive feedback was provided by patients, which demonstrated high levels of satisfaction of the outstanding care which was being provided. Staff provided emotional support to patients, identifying anxieties and responding to ensure the patient was at ease.
- The hospital was meeting its referral targets and most patients were seen within six weeks of their referral.
- Patients could access care and treatment with a choice of appointments offered to suit them, and care and treatment was only cancelled or delayed when necessary.

Summary of findings

- Arrangements to support patients with learning difficulties were in place, such as extra time for appointments and visits to the ward prior to admission.
- There had been no formal complaints regarding outpatients or diagnostic imaging in April 2016 to March 2016.
- The leadership, management and governance of the hospital assured the delivery of high-quality person-centred care. There were clear governance arrangements in place which reflected best practice and were managed proactively.
- All staff were encouraged to attend the monthly quality governance meetings and were actively engaged in the hospital's governance processes.
- Staff at all levels said information was always cascaded to keep them well informed.
- Feedback from staff was overwhelmingly positive about department and senior managers. The senior management team were visible, approachable and supportive.
- There was an excellent working culture within the department, which was patient focused and interactions with patients were positive. Staff were encouraged to identify ways to improve the service for patients and were empowered to make changes themselves.

However:

- Out of date medicines were found in one consulting room.
- Non-compliant flooring in the consulting rooms had not been risk assessed.
- Signage was not adapted to aid the vision of patients with impaired vision.

Summary of findings

Contents

Outstanding ☆

Peninsula NHS Treatment Centre

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Peninsula NHS Treatment Centre

The Peninsula NHS Treatment Centre is part of the Care UK group. The hospital opened in April 2005 and is located in a converted warehouse redesigned for healthcare purposes in Plymouth, 0.4 miles from the large NHS acute hospital serving the area.

The treatment centre treated only NHS patients which were referred via choose and book or may be seen on behalf of the local acute hospital. The referral criteria of the treatment centre excluded the following patients: under 18 years of age, patients with high suspicion of cancer, clinical emergencies, patients with poorly controlled morbidities, pregnancy, and patients with a body mass index of more than 42 for general surgery or more than 45 for local anaesthesia.

Patients were seen as outpatients at the start of their pathway to surgery either for initial consultations or for their pre-assessment clinic visit. Diagnostic imaging was performed on site. Patients underwent surgery as either inpatients or day care patients. During the period April 2015 to March 2016, 24.8% of patients stayed overnight following their surgery. There were 28 inpatient beds and 12 patient bays including four patient chairs. There were two operating theatres. There was one procedure room, and one pre and post anaesthetic care unit with five recovery bays.

Surgical procedures performed at the hospital included: cataract, hand, knee, hip, arthroscopy, hernia, cholecystectomy, foot, shoulder and tonsillectomy. The orthopaedic specialty accounted for 71% of outpatient attendances, followed by ophthalmology at 25% and general surgery at 4%. Several specialist services were outsourced to independent providers, such as: computed tomography, magnetic resonance imaging, ultrasound/ doppler; or to the local acute trust, such as: bone scan, nerve conduction studies and pathology and microbiology. The ophthalmology service was outsourced to an independent provider but based on the hospital site. The resident medical officer provision was outsourced to an independent agency.

The hospital opened in April 2005. In October 2014 the New Devon clinical commissioning group made a decision to cease commissioning care at the treatment centre as capacity could be met at the local acute trust and another independent provider hospital. This decision was withdrawn two months later following significant protest from the local population

The registered manager and accountable officer for controlled drugs for Peninsula NHS Treatment Centre was the hospital director, Patricia Warwick, who had been in the post since April 2015.

During this inspection we looked at surgery and the outpatient and diagnostic imaging service.

We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out a comprehensive announced inspection on 13 and 14 July 2016

2016 and an unannounced inspection on 30 April 2016.

Our inspection team

Our inspection team was led by:

Inspection Lead: Ruth Bryant, Inspector, Care Quality Commission

The team consisted of five CQC inspectors including a specialist inspector for pharmacy and a specialist inspector for radiology plus three specialist professional advisors including a consultant surgeon, a theatre nurse, and an outpatients nurse.

Summary of this inspection

How we carried out this inspection

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

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

To carry out this inspection we used a variety of evidence sources. The organisation provided us with detailed information prior to our inspection including for example, data from audits, patent satisfaction surveys, minutes of meetings, staffing figures. We heard feedback gathered from Healthwatch Devon and Healthwatch Plymouth, and consulted the clinical commissioning group for their feedback.

We met with three patients from the 'patient's forum' on Tuesday 12 July 2016 who shared their past experiences of care at the treatment centre. We visited the hospital on Wednesday 13 and Thursday 14 July 2016. We returned for an unannounced visit on Wednesday 30 April 2016 in the evening, to observe the hospital out of hours. During our time on site we spoke with 22 patients, three carers and 76 staff including the hospital director, the medical director, the head of nursing and clinical services manager and the clinical governance manager.

We held two drop-in sessions for all staff in the hospital to attend. We talked with doctors, the nursing and healthcare staff, physiotherapy team, members of housekeeping and catering, and administration and support staff. We inspected all areas of the hospital including wards, waiting areas, theatres, outpatient consultation rooms, diagnostic imaging rooms. We spent time observing care in the operating theatres, outpatients department, the diagnostic imaging department and the inpatient and day-case ward. We reviewed policies and procedures, training and staff records, and patient records where necessary. We collected 75 comments cards completed by patients, carers and staff during our on-site visit.

Although the surgery service and the outpatients and diagnostics service are inspected as separate core services in this report, the patients at Peninsula NHS Treatment Centre follow a joined up pathway of care whereby patients were seen as outpatients before or after their surgical intervention at Peninsula NHS Treatment Centre. Governance structures were shared across both services

Information about Peninsula NHS Treatment Centre

The Peninsula NHS Treatment Centre was registered for diagnostic and screening procedures, surgical procedures and treatment of disease, disorder and injury.

During April 2015 to March 2016, there were 1,100 inpatient episodes and 3,332 day case episodes The ten most commonly performed surgical procedures during this period included; cataract (1109), hand surgery (408), knee replacement (399), arthroscopy (399), hip replacement (399), hernia (239), cholecystectomy (215), foot surgery (212), shoulder surgery (115) and tonsillectomy (78).

During April 2014 to March 2016, the orthopaedic specialty accounted for 71% of outpatient attendances, followed by ophthalmology at 25% and general surgery at 4%. During the same period, 24.8% of patients stayed overnight following their surgery.

During April 2015 to March 2016, there were 7,473 adult outpatient appointments. These included 3906 first attendances and 3567 follow-up appointments. The diagnostic imaging departments x-rayed between 20-25 patients a day.

At the time of our inspection, the hospital employed 177 staff (110.8 whole time equivalent).

Summary of this inspection

The hospital director, Patricia Warwick, was the registered manager and the accountable officer for controlled drugs.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

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

Outstanding ☆

Surgery

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Information about the service

Surgery services at Peninsula NHS treatment centre provided non-urgent surgery for adults who met strict eligibility criteria to include being 18 years or over. The service included two fully ventilated operating theatres, one procedure room, a five bedded recovery area, a day surgery unit with 12 patient bays and four patient chairs for cataract surgery and a 28 bedded inpatient facility inclusive of two high observation beds. Additionally to the theatre and ward departments, the physiotherapy department worked closely with patients to enhance their recovery.

Between April 2015 and March 2016 there were 1,100 inpatient episodes and 3,332 day case episodes. All patients were NHS funded; no private or self-funded patients were treated at the hospital. Day case and inpatient surgery specialities included major and minor orthopaedics, ears nose and throat, general surgery and ophthalmology. The ten most commonly performed surgical procedures between April 2015 and March 2016 included; cataract (1109 episodes), hand surgery (408 episodes), knee replacement (399 episodes), arthroscopy (399 episodes), hip replacement (399 episodes), hernia (239 episodes), cholecystectomy (215 episodes), foot surgery (212 episodes), shoulder surgery (115 episodes) and tonsillectomy (78 episodes).

Patients accessed the service at Peninsula NHS Treatment Centre through referral by their GP or acute trust and if eligible were seen in the outpatient clinic before an appointment was arranged for surgery, all their follow ups post operatively were completed at the centre. The ophthalmology service was outsourced to an external company who provided their own consultants, patients received all care throughout their patient pathway at Peninsula NHS Treatment Centre. The local acute trust also ran theatre lists at the centre with their own consultants, but nurse staffing was provided by Peninsula NHS Treatment Centre. For these patients pre-operative and post-operative assessments were not completed at the centre, patients were confirmed to meet the eligibility criteria and attended their allocated surgery date. These patients received day case or inpatient care following surgery.

During our inspection we visited the surgery service on the 13 and 14 July with an unannounced evening visit on the 20 July. We visited the inpatient ward, day surgery unit, theatres, post anaesthetic recovery unit and the central sterile services department. We spoke with staff to include the hospital management team, department managers, and clinical and non-clinical staff across the hospital. We met with 10 patients and three members of the patient forum and obtained patient feedback through 71 comment cards. We observed care and looked at records and data.

Outstanding ☆

Surgery

Summary of findings

Surgery services at Peninsula NHS Treatment Centre were rated to be outstanding overall. We found:

- There were clear processes in place to ensure the safety of patients. Incidents were reported and investigated and as a result action was taken and learning shared.
- All areas of the hospital were visibly clean to a high standard; staff demonstrated good infection control practice to reduce the risk of infection.
- Comprehensive risk assessments were completed for patients and their application was audited to ensure harm free care and the ability to assess and respond in a timely way to patient risk.
- Equipment appeared fit for purpose and was well maintained. Staff received training when new equipment arrived to ensure they were competent in its use.
- The electronic patient record allowed for clear, complete and accurate records to be maintained for the patient throughout their pathway.
- Staff had appropriate training and when spoken with had good knowledge.
- There was a resuscitation team and equipment readily available to respond to an emergency situation. Processes were in place to transfer patients to the local acute trust.
- Nursing and surgical staffing was reviewed regularly in line with best practice guidance and safe staffing levels were observed.
- Evidence based guidance was used to plan and provide care and treatment to help improve patient outcomes. Patient outcomes were regularly monitored.
- Pain relief, nutritional and hydration needs were all assessed and effectively managed.
- Staff were competent and the multidisciplinary team working was excellent throughout the departments and different job roles.
- Staff obtained both written and verbal patient consent throughout the patient pathway.
- Consistent positive feedback was provided by patients who demonstrated high levels of satisfaction of the outstanding care which was being provided.
- Care was person-centred and staff were both compassionate and professional. Patients were kept involved with their care and staff ensured their full understanding.
- Exceptional effort was made by multidisciplinary teams to accommodate the specific cultural needs of patients during their inpatient stay.
- Emotional support was provided to patients. Staff were observed identifying anxious patients and putting them at ease.
- The service was responsive to and accommodated patients' needs, and where possible enabled patients to access care at a time that suited them.
- The leadership, management and governance of the hospital assured the delivery of high-quality person-centred care. Staff were encouraged to take part in monthly quality governance meetings and this promoted a learning culture within and across teams.
- Clear governance arrangements were in place and risks were identified and managed. The quality of the service was monitored through an extensive audit programme.
- The senior management team were visible, approachable and supportive, encouraging an open and fair culture.
- There were high levels of staff satisfaction across all equality groups. Staff were extremely proud of the hospital as a place to work and spoke highly of the culture.
- Feedback from people who use the service was actively sought and used to make improvements.

However:

- Out of date medicines were found in the ophthalmology trolley in the day surgery unit.
- Medicines were pre-prepared and left unattended in the anaesthetic room, this was not included in the hospital's risk assessment.
- The humidity levels of theatres were not maintained at an appropriate level.

Outstanding ☆

Surgery

Are surgery services safe?

Good

Overall, we have rated the safety of the surgery service as good because:

- There were clear processes in place for reporting incidents and staff confirmed and provided examples of how feedback and shared learning was received.
- Harm free care was monitored using the safety thermometer and the hospital assessed patients and monitored pressure ulcers, falls, venous thromboembolism and catheter associated urinary tract infections.
- The ward and theatre departments were visibly clean. The hospital monitored infection control through a regular audit programme. Good infection prevention control practice was demonstrated to reduce the risk of infection.
- Equipment appeared fit for purpose and was well maintained.
- Records were complete, accurate, legible and up to date. On review of records comprehensive general assessments and risk assessments were completed throughout the patient pathway.
- Staff were knowledgeable about the safeguarding processes and understood their responsibilities to report concerns to the safeguarding lead for a referral to be raised.
- Training records showed mandatory training achieved 97.2% compliance for all hospital staff.
- Surgical staff followed the World Health Organisation (WHO) safe surgery checklist.
- Processes were in place to respond to a deteriorating patient, there was a competent resuscitation team and staff had knowledge of emergency transfer procedures.

However:

- Out of date medicines were found on the ophthalmology trolley in the day surgery unit.
- WHO safe surgery checklists were completed verbally and retrospectively entered on to the electronic patient record, there is potential risk information is recorded incorrectly.
- One theatre's humidity was below the recommended humidity level.
- Two staff were seen not to be adhering to infection prevention and control guidelines.
- Pre-prepared medicines were left unattended in anaesthetic room; this was not included in the hospital's risk assessment.
- Patient files were left unattended in the unlocked high dependency unit room.

Incidents

- Records showed there was a consistent rate of clinical incident reporting. Incidents were reported on the provider's electronic reporting system; clinical managers reviewed each incident and investigated where necessary. There had been 83 clinical incidents and 48 non-clinical incidents within surgery or inpatients between April 2015 and March 2016.
- There had been two serious incidents between April 2015 and March 2016. These incidents had been reviewed through the governance processes, completing a root cause analysis. Lessons learned were shared and changes made. The Clinical Commissioning Group were informed.
- All incidents were discussed at the monthly quality governance assurance meetings. Staff spoken with had a clear understanding of clinical and non-clinical incidents and how these should be reported. They said the incident reporting system was easy to use. Staff told us any identified feedback and learning from incidents was given individually and cascaded to staff through team meetings, handovers and communication books.
- Mortality and morbidity was discussed as part of the monthly Quality Governance Assurance meeting. Any deaths were investigated fully, there were no themes identified. Between April 2015 and March 2016 there were no inpatient deaths. One unexpected death in April 2016 was reported of a discharged patient 19 days following a left total hip replacement. A root cause analysis was completed and did not show any link to treatment or issues whilst an inpatient.
- Staff provided the following examples of how learning or changes had been made as a result of an incident:
- In the theatre department a sterile set was collected from the sterile store room, before the operation it was noticed the tape on the set had not changed colour indicating the set was not sterile. As a result of this

incident a dedicated autoclave technician was put in place. Diagrams were now displayed in the sterile store room to clearly indicate to staff the colour change before and after sterilisation.

- Staff were encouraged to report incidents with the anaesthetic machines which supported the business case to replace the faulty machines; we saw evidence of this in the incident report.
- As a result of an incident where a patient's surgery was cancelled as their skin was compromised, there was a new procedure document in place for patients with compromised skin.
- In theatre an empty carbon dioxide cylinder was reported due to the failure of staff to turn off the cylinder when not in use. We were informed the theatre manager effectively communicated the change in process to staff and a link member of staff was appointed.
- Additionally, learning from incidents was also shared corporately from other Care UK providers.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffered harm or could suffer harm which falls into defined thresholds.
- Staff were educated in the duty of candour; they had access to the Care UK corporate policy and completed a duty of candour training module. Theatre and ward staff had 100% compliance with this training module.
- Staff spoken with understood the duty of candour and could provide examples of how this would be applied. They explained how they would be open and honest with patients and provide an apology, should something have gone wrong.

Safety thermometer

- The hospital participated in the national patient NHS safety thermometer. The safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm-free' care on one day a month. This includes falls, pressure ulcers, venous thromboembolism (VTE) and catheter associated urinary tract infections. The safety thermometer was not on display in the hospital. The head of nursing and clinical services maintained a safety thermometer dashboard. Between July 2015 and July 2016 100% harm free care had been delivered.
- The number of cases of hospital acquired VTE was zero. VTE is the formation of blood clots in the veins.

Cleanliness, infection control and hygiene

- All surgical and ward areas appeared visibly clean. Alcohol hand gel disinfectant was available at entrances to the main ward, day surgery unit and theatre areas and on entrance to patient rooms and at bed spaces. Equipment appeared clean and there was use of 'I am clean stickers', which included the date of cleaning, to indicate equipment was cleaned and ready for use. We observed staff clean equipment and apply these labels. Curtains had the date they were changed clearly displayed, staff informed us these were changed every six months and all curtains were within this period.
- When speaking to staff and patients many people positively commented on the cleanliness of the hospital. Staff said the hospital was regularly cleaned by the housekeeping team and patients were impressed on how clean the hospital remained throughout their inpatient stay.
- Processes were in place to protect patients from hospital-acquired infections. Patients were tested for methicillin resistant Staphylococcus aureus (MRSA) through taking a swab of the nose, throat and groin during their pre-operative assessment in outpatients. The patient administrator confirmed MRSA tests had been completed against the theatre list prior to admission. Between April 2015 and March 2016 there were no incidences of hospital acquired infections, including MRSA, methicillin sensitive Staphylococcus aureus (MSSA), Clostridium difficile and Escherichia coli.
- There were two surgical site infections reported in the period April 2015 to March 2016 for knee replacement surgery, but none for hip replacement surgery. The patient administrator informed patients to shower and to not wear any jewellery, make-up or nail polish, to reduce the risk of surgical site infections. The traceability system in the theatre department allowed a trace back to the patient if there was an infection. For the two surgical site infections root cause analysis was undertaken and recommendations made for lessons to be learnt. The recommendations were communicated internally through reporting to management and

disseminating via departmental, clinical governance and heads of department meetings, and were documented in the patient's notes. Externally the patients' GPs and Public Health England were informed. Surgical site infections were monitored by the infection control lead. Details of infections were submitted to Public Health England. Patients completed a surgical wound healing discharge questionnaire 30 days after surgery. At the time of inspection there was a 70% response rate. Any patients who did not respond were phoned. If infection was noted the patient would be contacted along with their GP to gain further information and understand the treatment they received and why they required this treatment. The infection control lead said they were able to contact Public Health England if they should have any queries.

- An infection control lead was present in the hospital and infection control link nurses were within each department. All link nurses received corporate training and were responsible for completing infection control audits in their department. Infection control meetings were held monthly. For the period between March 2015 and April 2015 an annual infection prevention and control statement was produced for Care UK.
- Staff received training on infection control and compliance was at 100% in April 2016. Staff said they were able to access all infection control policies electronically.
- On the whole staff demonstrated good infection control practice. All staff were observed to be bare below the elbow. Staff were observed washing their hands and using hand gel between patients, and wearing personal protective equipment to include gloves and aprons. Techniques for hand washing signs were displayed with the sink facilities throughout the hospital. During our inspection two staff members were observed wearing gloves following leaving a patient's room. There was a potential risk these were dirty gloves and therefore pose an infection control concern.
- Cleaning checklists were in place and complete to ensure the ward and theatre departments were cleaned regularly. A dedicated theatre housekeeping team worked in the evenings (7pm to 12am), additionally to daily cleaning schedules a deep clean was completed every six months.
- In the theatre department the flow of sterile and contaminated equipment was appropriately segregated. Sterile instruments came in to theatre via one route and contaminated instruments left the theatre by another route. A back corridor was assigned as the dirty corridor and connected to the central sterile services department for the first stage of disinfection.
- The hospital's central sterile services department had a British Standards Institution (BSI) certificate of registration for the provision of their service of decontamination and moist heat sterilisation of surgical instrument sets. An unannounced BSI inspection found no outstanding and no new nonconformities, confirming compliance with international organisation for standardisation (ISO).
- We observed a clean linen store; all linen was suitably arranged and kept off the floor. Cleaning of linen was outsourced; the linen services collected dirty linen and replaced with clean linen. Dirty linen was held in the sluice areas and then transferred to a cage for collection by the linen services.
- A monthly infection prevention control audit schedule was followed in the hospital. A cleaning audit score sheet was maintained and designed along the national cleaning standards documents. Audits were completed in all departments to include the main ward, day ward, operating theatre and clinical sterile services department. The corporate target for audits was 75%; however the hospital aimed for 98%. Action plans were put in place when compliance was below target levels.
- The hospital had adopted the safer sharps initiative to protect healthcare workers and patients from the dangers of needle stick injuries.
- All taps in the hospital were flushed weekly for five minutes at a time. Records of this were seen and a three monthly de-scale of all showerheads was completed.

Environment and Equipment

- The hospital had adequate security systems in place to protect patients and staff. This included CCTV connected to the reception and the ward. Staff said they felt safe in their working environment. Out of hours the site was locked and an outsourced security team performed checks of the area. The security team were available to contact at any time if staff had concerns. Staff provided an example of calling the security team, who responded quickly and then drove by the hospital intermittently for the rest of the shift. At the end of the theatre housekeeping shift at 12am security escorted staff and ensured they were safely in their cars.

- The layout of the premises ensured a safe environment. Fire exits were clearly marked with no obstructions. Fire extinguishers and fire blankets were in date of their annual checks.
- Windows had restricted opening to prevent the risk of falling from windows.
- On observation the ward décor appeared tired, however, it was confirmed the ward area was due for painting.
- There were plans for the refurbishment of the equipment store in the theatre department, at the time of our visit some stock was being kept in boxes on the floor. The refurbishment would enable stock to not be placed on the floor and aims to maximise the space.
- We did note in one theatre the humidity was at 13% and therefore creating a dry atmosphere which increases the risk of fire if flammables were used. The humidity should be at 55%. When speaking to estates they informed us this is the result of the temperature being manually changed in theatre and this would need addressing with the theatre department.
- Waste arrangements were in line with national guidance. Sharps bins were observed to be temporarily closed when not in use; they were not overfilled and were labelled and dated.
- Resuscitation trolleys were located in the main ward, day surgery unit and recovery, each was secured with a tamper evident tag. We confirmed trolleys were checked daily. There was correct stock of equipment which was in date. The difficult airway trolley was also in the recovery room and was well stocked and checked daily.
- Oxygen cylinders were seen to be present at an appropriate fill level and in date. Two additional small cylinders were available for patient transfer or if a patient needed to go to the bathroom.
- All equipment observed appeared fit for purpose.
- In the annual staff survey 2015, 74% of staff said they had the materials and equipment to do their job. Talking to staff throughout our inspection all staff were happy with the equipment they had available which allowed them to complete their job safely and they said equipment was well maintained. One anaesthetist commented equipment was top rate.
- Staff provided examples of new hospital equipment and confirmed they were provided with training to ensure they were competent in using it safely. For example following implementation of the new anaesthetic machine staff were provided with two weeks support by an external representative.
- Equipment was maintained and serviced by the local acute trust's microelectromechanical systems (MEMS). Estates provided records of up-to-date servicing of equipment. Staff said in the event of equipment failure there was a very quick turnaround. Someone would be sent to repair the equipment within 24 hours or equipment would be taken away to be repaired and equipment loaned in the meantime.
- We were informed all equipment was compliant with the Medicines and Healthcare products Regulatory Agency (MHRA). If a product failed then the head of nursing or clinical governance manager would be informed to feedback to the MHRA. We saw evidence of a log maintained of MHRA alerts
- Electrical portable appliance testing was completed annually and the next test was booked for July 2016.
- The anaesthetic room was an appropriate size to undertake safe anaesthesia, with room to manage a cardiac arrest or other unexpected event. The layout ensured easy to find products with minimal stock stored in cupboards and drawers.
- Daily checks of the bed spaces on the main ward were completed and we saw records of this. Checks included suction, oxygen, non-re-breather, nasal prongs, call bells, bed and brakes and gel dispensers.
- The intersurgical anaesthetic machine daily check log book showed an occasional no entry; this appeared to demonstrate the checks were omitted on four occasions (Thursdays and Fridays) in May and June 2016. Otherwise records had been completed.
- Weekly scheduling meetings were held and highlighted if any special equipment was needed or if there was an increase in certain procedures to enable the clinical supplies leader and team to order specialist equipment. Theatre board meetings were held daily and could be used to confirm equipment requirements for the day.
- There was appropriate control of swabs, instruments and needles in theatres. The scrub nurse and circulating practitioner jointly accounted for surgical instruments, swabs needles and miscellaneous items prior to start of surgery, during and at the close, according to standards recommended by the Association for Perioperative

Practice (AfPP). Tracking and traceability was evident and recorded in the patient record. Swab white boards were in use in theatres in clear view of the scrub nurse and consultant.

- All equipment was checked and electronically scanned for traceability, and checked against the checklist. A paper system was available as back up. Any discrepancies would be raised with theatre staff immediately. The clinical sterile services department said they were able to meet the demands of the theatre list. Equipment was sterilised in order of priority to ensure equipment was available for later in the day or the next day.
- The central sterile services department was ISO accredited and was subject to bi-annual audits. Daily, weekly, quarterly and annual checks were completed on the machines of the central sterile services department. We saw records of completed checks. We were informed no lists have been cancelled as a result of failures to machines, only slight changes have been made to a list if equipment was not ready. There was spare capacity if a machine goes down and staff would work to get priority equipment through. There were arrangements with the local acute trust in the event of failure.
- An implant register was maintained by the theatre manager, this included the patient and prosthesis labels. The theatre manager confirmed this record was kept for 12 months in their office before being archived.
- The clinical supplies team completed a monthly stock take, to include checking of expiry dates and ensuring stock rotation. On review of a random sample of equipment in the store room and across the theatre, ward and day surgery departments all were in date. If equipment was close to its expiry date it was clearly identified.
- An external contractor serviced the generator and we saw records of this. The company provided a four hour service level agreement to the hospital if errors could not be fixed locally. The generators worked on essential and non-essential power supplies. Theatres utilised uninterrupted power supply back-up. This was recently required following a power outage. The theatres were able to complete their procedure and the remaining list cancelled.
- Theatre revalidation was carried out annually and we saw evidence of this last performed in April 2016, filters were replaced at this time. Air handling units in theatres had their filters changed monthly, the recommended change from the manufacturers is six monthly. Records of these changes and servicing were seen. Back up motors for these units were also checked monthly and all work was undertaken on governance days to minimise clinical disruptions.
- Risk assessments were in place for personal protective equipment, permits to work, risks and hazards and tools and equipment.
- There was a monthly temperature check of all taps and showers.
- Medical gases were checked daily. There was a three monthly air quality check and planned preventative maintenance. A contingency plan was in place for failed piped gases.
- The hospital provided a range of equipment to meet patients' post-operative needs. This included a toilet seat rise, walking frames, crutches, wheelchairs, leg lifters, long-handled shoe horn, grabber to pick up items, flat shoes and other supports. Physiotherapy used mock therapy stairs to ensure patients were capable of completing stairs before returning to their homes.
- The hospital had access to a hoist. There was no bariatric equipment, however the theatre manager confirmed there was no need because patients who would require this equipment would not meet the hospital's surgery criteria.

Medicines

- The hospital had an onsite pharmacist and pharmacy assistant. The pharmacist attended the daily multidisciplinary ward rounds. The pharmacist was responsible for screening to take out medications and inpatient drug charts. The pharmacist captured and reported any interventions.
- An external wholesaler supplied the medicines. Arrangements were in place for the emergency supply of controlled drugs from the local acute trust. If medicines were required out of hour's arrangements were in place for private prescription supply from an external pharmacy.
- Staff were aware of their medicines management responsibilities and had access to the hospital's medicines management policy to include information on obtaining, recording, handling and storing medicines.
- We observed medicines in the theatre and ward departments to be in date with the exception of

medicines on the ophthalmic trolley in the day surgery unit. We found two 20ml water for injection expired in September 2014 and one in June 2016. One 20ml sodium chloride 0.9% injection expired in January 2016 and four in April 2016. Staff removed and disposed of these medicines at the time of inspection. We observed short shelf life medicines clearly identified with stickers.

- Prescription pads were held securely.
- We observed medicines to be stored in drug fridges and temperature checks completed and recorded daily were within correct limits. We did identify one missed fridge temperature in one anaesthetic room at the date of inspection.
- We observed medicines to mostly be stored securely in the theatre and ward department. We found the ophthalmic trolley in the day surgery unit was not secure; it was not locked and was kept in a bay which could not be locked. In theatre, the anaesthetist drew up medicines prior to use and labelled syringes. We observed four labelled syringes unattended in the anaesthetic room during a theatre list. Recently revised guidance issued by the Royal College of Anaesthetists says this can happen but it needs to be part of a risk assessed process. We reviewed the health care risk assessment form for pre-prepared injectable medication within the anaesthetic room, this did not include pre-prepared medicines left unattended in the anaesthetic room.
- To take home medicines were regularly monitored with daily checks and we observed the register for to take home medicines completed.
- There were systems in place to make sure patients received their medicines in a timely way, both throughout their time at hospital and at discharge. Arrangements were in place to ensure the supplies were available when the on-site pharmacy was closed.
- Emergency medicines and equipment were available and there were systems in place to make sure these were within their expiry date.
- Records of administration were completed correctly and there were clear records where medicines had not been administered as prescribed.
- There were clear arrangements in place to manage medicines brought into the hospital by patients and these were stored securely. On the inpatient ward a patient would be assessed for their competency of self-medicating and their medicines stored at their bedside in the lockable patient locker. At the time of our inspection, one patient was self-medicating and a risk assessment was completed.
- We reviewed controlled drug records and real time recording of drug usage was evident. The responsible person and witness completed the controlled drugs book and maintained stock entries according to legal requirements and medicine management standards. Balance checks were completed and recorded twice daily, the requirement for twice daily checks was part of an action plan following incidents regarding drug errors and would be reviewed in July 2016. The controlled drugs register included the staff specimen signatures, which provides samples of authorised staff signatures. Patient controlled analgesia wastage was recorded. On the ward patient's own controlled drugs were recorded and there were clear records of the return to the patient.
- The hospital had been issued with a controlled drugs licence. Controlled drugs destruction kits were available, staff spoken with were aware of the process for destruction. The regional pharmacy technician and the head of nursing and clinical services were authorised as witnesses for controlled drug destruction.
- The hospital director was the Controlled Drug Accountable Officer; they demonstrated regular interactions at the controlled drugs local intelligence network to allow sharing of the management of controlled drugs. The hospital director fed back learning from these meetings through the governance meetings.
- We reviewed 13 prescription charts, three for patients on the ward and 10 archived patient notes. Medicine records were complete with allergies, doses and signed dated and time for administration of medicines.
- The hospital's reception office held an anaphylaxis kit and first line resuscitation drugs; we saw evidence of monthly checks of these being recorded.
- Nurses used patient prescription charts during their nursing handover to discuss medication in detail which included any medication prescribed, administered through the day or required through the night shift. The nurses emphasised any patient allergies.
- In the discharge pack patients were provided with information of their medicines to take home, highlighting medication names, informing what the

medicine was indicated for and the frequency of taking the medication. Staff also recorded the last time paracetamol was taken and when patients were allowed to take the next dose.
- The pharmacy team undertook medicines management audits on an annual basis. They completed a controlled drug documentation audit quarterly. An anaesthetic observation audit, including preparation of medicines and medicine storage, was completed quarterly.
- The hospital identified a medicines management issue where drawn up ketamine was being used for more than one patient, rather than disposing remaining quantities. We were informed some consultants did not want to waste resources. Management were informed and this was raised through clinician feedback. At the time of our inspection we did not see evidence of this during theatre observations or within the controlled drugs registers.

Records

- Patient records were held securely and maintained patient confidentiality.
- The hospital used a secure integrated care pathway electronic patient record which documented care, treatment, general assessments and risk assessments for each stage of the patient pathway; pre-operative assessment, pre-operative calls, admission, surgery, post-operative care, discharge and post-operative calls and follow-ups. Additionally, any hard copy documents or signed consent was held on patient files which were stored securely on the hospital site. In the event the electronic system failed a paper plan was available.
- We reviewed 10 archived paper records and performed a complete electronic record review for three of these records. We also observed records completed in all departments at the time of our inspection. All records were complete, accurate, legible and up to date. All clinical staff completed informative evaluation notes, we reviewed these for nurses, healthcare assistants, physiotherapists, consultants and the resident medical officer, and all were dated and electronically signed.
- National early warning signs (NEWS) observation charts were completed in all 10 archived patient files and for patients in the hospital at the time of our inspection. On review of these observation charts the frequency of monitoring patient's physiological parameters was in line with NEWS guidance.
- Labels of implants and materials used were present in all archived patient files.
- The electronic patient record included arrangements for discharge and a discharge checklist to include clinical activity, medication supplied and patient education. We reviewed copies of discharge summaries on the electronic patient record.
- A documentation audit was completed quarterly. In February 2016 the documentation audit achieved 100% compliance.
- We did identify patient paper files left unattended in the unlocked room of the high dependency unit.

Safeguarding

- Staff spoken with were knowledgeable about the hospital's safeguarding processes and understood their responsibilities. They would escalate any concerns to the safeguarding lead. There was a corporate safeguarding policy and a local procedure for the hospital. The local procedure included a contact number to make a safeguarding alert. A safeguarding folder was available on the ward and included local authority contact numbers.
- The ward manager was the safeguarding lead for both adults and children. They had undertaken safeguarding level four training and attended local safeguarding meetings. They informed us safeguarding referrals were minimal and they had only completed one in the last year.
- Staff said the quality of safeguarding training was good and they had received a training session on female genital mutilation. In June 2016 the mandatory training records showed 95.8% compliance with safeguarding adults training, 96.3% compliance with safeguarding children training level two and 95.8% compliance with child protection training.
- A quarterly safeguarding audit was completed to evidence to commissioners how the safeguarding of vulnerable adults and children was being managed. In January 2016 the hospital were partially compliant with safeguarding adults, they fell down due to interdisciplinary responsibilities where it was commented they were still trying to establish links with the clinical commissioning groups. The ward manager confirmed these links had started to be established.

Mandatory training

- Staff completed mandatory training, which included face to face and e-learning. There was a training matrix identifying training requirements and regularity of training for different job roles.
- Staff training analysis reports were produced every month and discussed at the heads of department monthly meetings.
- We saw records dated June 2016 and overall the hospital compliance with mandatory training was at 97.2%. Training included; prevent training, basic life support, equality and diversity, fire safety, moving and handling, health and safety, infection control, medicines management, mental capacity act and deprivation of liberty safeguards, safeguarding adults, child protection, safeguarding children level two, safeguarding adults level two, information governance, patient consent, clinical governance and duty of candour. Training compliance was appropriate for the theatre and ward department and consultants, the data showed compliance at amber in three instances for basic life support on the ward and safeguarding adults and children level two for consultants, where one person was not up-to-date with their training. The hospital monitored training compliance on a regular basis.
- Staff said mandatory training was of good quality and was easy to access. They were provided with alerts when their training was due to expire to enable them to keep up-to-date. Staff found the governance days useful to allow them to complete training and be provided with additional training. One comment was made for training to be improved by making it theatre specific, for example moving and handling.

Assessing and responding to patient risk

- The exclusion from surgery criteria included patients who were under 18 years of age, had a high suspicion of cancer, were a clinical emergency, had poorly controlled co-morbidities, pregnant or with a body mass index more than 42 for general anaesthesia or more than 45 for local anaesthesia.
- Care records were complete for each patient and included information throughout their patient pathway. General health assessments, investigative tests, current medication and known allergies were recorded to allow staff to assess and minimise risk of adverse surgical outcomes.
- Risk assessments were used to keep patients safe and were in line with national guidance. Risk assessments included; venous thromboembolism (VTE), water low, falls, manual handling, repositioning, visual phlebitis and neurovascular observations. From review of three electronic records these assessments were completed regularly, where applicable in pre-operative assessment, at admission, in recovery, in the day surgery unit and throughout a patient's stay on the inpatient ward.
- Patients were assessed for the risk of falls. Patients were told to wear slippers or shoes when walking on the inpatient ward and encouraged to use their call bell should they require assistance. If a patient experienced a fall, staff completed a full investigation using the fall audit. We observed patients on the ward walking with safe foot wear and mobility aids.
- Patients with pressure ulcers were not operated on as there is more risk for infection. Staff informed us skin was checked daily for pressure ulcers and following surgery they aimed to get patients mobile to reduce the risk of skin becoming compromised. The hospital had links with the local acute trust's tissue viability team should they require advice and could order pressure relieving equipment. An example was provided of an air mattress requested recently for a patient with rheumatoid arthritis.
- All patients on admission and within 24 hours of admission received an assessment of VTE and bleeding risk, in line with the National Institute for Health and Care Excellence (NICE) quality standard three (QS3). VTE was monitored twice daily throughout a patient's inpatient stay. VTE audits were completed monthly to include VTE patient pathway audit which consisted of a smaller focused tool. The second full VTE audit tool was undertaken quarterly. Additionally, if the VTE patient pathway audit identified non-compliance or a concern then a full VTE audit was required. The hospital monitored the rate of assessment for VTE completed on admission. Between April 2015 and March 2016 the percentage of patients risk assessed for VTE was below 95%. In March 2016 99.6% compliance was achieved.
- Catheters and urinary tract infections were monitored. Patients were provided with a one off gentamicin (antibiotic) to prevent the risk of urinary tract infections. Where possible catheters were removed day one post operatively. Staff monitored urine output and ensured this, along with patient mobility, was satisfactory before removing the catheter. Staff said infections would be treated immediately.

- Patient care was consultant led and consultants reviewed care and confirmed treatment daily. The resident medical officer was on site and out of hours was available for nursing staff to contact. An on-call team of consultant anaesthetists and consultant surgeons were available to respond to patient risks, there was also a rota for an on-call theatre team.
- Patient's surgery would be cancelled if changes had occurred since their pre-operative assessment. Patients would not be operated on if they had been unwell or if they had a pressure ulcer. We saw an example of a root cause analysis completed for a surgical procedure abandoned due to a patient being found to have pressure ulcers. We observed a nurse at admission checking and discussing with the patient their skin viability.
- An allocated high dependency unit room was set up with a bed and monitor for emergency cases. There was a local standard operating procedure in place which clearly defined the escalation process and the individuals and roles engaged if a patient deteriorates. A flow chart was developed with instructions for staff to ensure prompt access to emergency ambulance crews out of hours. There was a service level agreement in place with the local acute hospital where there were critical care facilities to which patients could be transferred if clinically indicated. Staff had a good understanding of the processes they would follow should a patient deteriorate and an emergency transfer is required. The week prior to our inspection a transfer of a patient was required; the anaesthetist said there was a good response from staff. The consultant anaesthetist will decide who transfers with the patient; this is normally the anaesthetist, ward manager or senior member of staff. The patient's notes were printed and photocopied to transfer with the patient.
- There was a local cardiopulmonary resuscitation procedure. This outlined the resuscitation team to include; a consultant anaesthetist, resident medical officer, resuscitation officer, theatre appointed person, shift leader on the ward and ward manager or deputy. Out of hours the team consisted of the resident medical officer, shift leader on the ward, ward staff and on call anaesthetist. The resuscitation team held a resuscitation bleep which was tested daily, on both days of our inspection we observed this test being completed. The resident medical officers, anaesthetists, resuscitation lead and deputy theatre manager were trained in advanced life support. The physiotherapy team, two surgeons, nurses in theatre, ward and outpatients, clinical governance manager, theatre manager, ward manager and outpatient manager were trained in intermediate life support. A trained basic life support assessor worked at the hospital and delivered training as required. The hospital held cardiac arrest scenarios quarterly. We saw examples for March and July 2016, and these were attended by required members of the multidisciplinary team. The emergency scenario audit tool kit assessed compliance with these scenarios and identified lessons learned and points for improvement, supported by an action plan.
- The National Early Warning System (NEWS) was used for patient observation in recovery and during their stay on the ward. This tool enabled the clinical risk of patients to be assessed for early detection of a deteriorating patient. NEWS was audited monthly through review of 20 patient records. For February and March 2016 100% compliance was achieved. Non-compliance was seen in January 2016 with 94%. The audit data showed the use of NEWS was being regularly monitored and actions put in place when non-compliance was identified.
- Patient temperature was monitored before, during and after surgery to limit the risk of perioperative hypothermia, in line with NICE guidance. Warming blankets were available if an anaesthetised patient's temperature drops. Anaesthetised patients are unable to regulate their temperature increasing the risk of hypothermia, this is associated with higher mortality rates, longer stays in hospital and increased rate of wound infection. Monitoring a patient's temperature limits these risks.
- Safe practice was observed in theatre:
- The patient was connected to the anaesthetic monitoring machine and a regional block was administered. The patient was transferred to the theatre prior to the administration of general anaesthetic. The anaesthetist used this approach to avoid risk of harm during disconnection of oxygen and monitoring when transferring the patient from the anaesthetic room to theatres. The monitoring system ensured continuous monitoring and an uninterrupted record of events and therefore was safer for the patient.

- The whole team were in attendance in supporting the patient's limbs when carefully positioning them prior to surgery. Theatre staff gave much attention to using positioning gel pads and other supporting aids to prevent inadvertent injury.
- Throughout the surgical procedure and in the recovery room following surgery patient warming devices were in use in conjunction with temperature monitoring, this was in accordance to NICE guidelines.
- Recovery staff applied VTE stockings to the limb following surgery.
- World Health Organisation (WHO) safer surgery checklists were used in theatre, to include a specific surgical safety checklist for cataract surgery. On observation in theatre the WHO checklists were completed verbally and in full to include skin marking of the surgical site, and all staff stopped their activities to be fully engaged. We observed the identity of the patient being confirmed correctly and positively, checking the bracelet and the mark site with the patient. The checklist was completed verbally, however was not recorded at the same time as it was said. Following the verbal completion of the checklist, the information was retrospectively inputted on to the electronic system, which caused a potential risk that information was recorded incorrectly. On review of three electronic patient records we confirmed the checklists were completed. Observational WHO audits were completed monthly and surgical safety checklist audits daily. Non-compliance was identified in the surgical safety checklist for only one date between January and March 2016. There were eight out of 17 safety checks missed on an orthopaedic day theatre list. The theatre manager confirmed this was one consultant who was not engaging in the WHO checklist. Feedback was provided to all staff and improvements had been seen as a result.
- As part of the WHO five steps to safer surgery checklist a team briefing and de-briefing was completed. All staff attended the team brief prior to the arrival of the first patient on the theatre list. Staff introduced each other to include introduction of the CQC observer. The brief was thorough and all patients were discussed. Staff also completed a team de-brief at the end of the theatre list; we did not observe a team de-brief but reviewed completed de-briefing sheets for June 2016.
- We observed one nursing handover between the day and night shift on the inpatient ward. Each patient was discussed in detail, to include the care they had received and the care they would need, highlighting any risk areas. A nurse explained how they were not satisfied with a patient's temperature and therefore obtained a warming blanket from surgery to warm the patient. Patient wounds were also discussed in detail.
- We were informed that intentional rounding, whereby nurses conduct checks of patients at set times, was completed only if a patient was unwell, restless or confused. There were no patients subject to intentional rounding at the time of our visit.
- Patients were provided with discharge information to include managing their surgical wounds, thrombosis, and reducing the risk of developing blood clots. This provided patients with awareness of risk areas.
- Patients were provided with a hotline number to contact following discharge should changes to their condition arise or if they need advice. They were also telephoned by nursing staff the day following discharge to check on their condition. This is in line with Association of Anaesthetist of Great Britain and Ireland (AAGBI) and British Association of Day Surgery (BADS) guidelines for day case and short stay surgery.

Nursing and other staffing

- Staff spoken with said nursing staffing levels were appropriate to ensure patients were safe both during the day shift and night shifts. During our inspection staffing levels appeared safe in the ward, day surgery unit and theatre departments.
- The ward and day surgery unit staffing model was based on the Shelford safer nursing care tool, in line with NICE guidelines. On the inpatient ward a daily patient flow information sheet was completed, recording the dependency level of patients to allow staffing to be adapted if required. A safe staffing board was displayed informing patients and their relatives if staffing was; appropriate and safe, understaffed however safe or not safe and if it had been escalated. A ward manager and deputy ward manager were in place and shift leaders were allocated. At the time of our inspection there were 14.9 full time equivalent nurses and 6.3 full time equivalent health care assistants. Two nurses would be allocated during the night shift; they were supported by a healthcare assistant who worked between 7pm and 12am.
- The theatre staffing model followed the Association for Perioperative Practice (AfPP) guidelines. A theatre

manager and deputy theatre manager were in place and shift leaders were allocated. The theatre manager informed us they would cancel a list if they were not safely staffed. The late team started at midday and we were informed this had improved the efficiencies in the department. A second healthcare assistant would be allocated to theatre in the event of major joint surgery, and this was present in the daily staff allocation records. At the time of our inspection there were 11.9 full time equivalent theatre nurses and 10.7 full time equivalent health care assistants and operating department practitioners.

- The heads of department planned staff cover for the month based on the planned schedule. Planned staffing was updated weekly and daily based on actual activity. Weekly scheduling meetings were held and allowed departments to look at activity, for example the number of major and/or minor operations to plan ahead and predict staffing levels. Managers reviewed patients and where possible tried to accommodate needs, for example ensure the dementia lead was working when a patient living with dementia was booked for surgery. Additionally, if a patient was living with dementia, staffing would need to be adapted to ensure capacity to provide one to one care.
- There was an on-call theatre team out of hours to include a scrub nurse, anaesthetic assistant (or scrub nurse with competencies) and an additional staff member to act as the circulator.
- Nursing staff on the ward completed handovers between the day and night shift. We observed an extremely thorough handover.
- Nurses on the ward had additional responsibilities as a link nurses on for areas to include; NEWS, safeguarding, dementia, infection prevention control, resuscitation, training, student nurse/university, health and safety and manual handling.
- All shifts were filled in the inpatient and theatre department between January and March 2016.
- The rate of use of bank and agency staff between January and May 2016 averaged 8.9% inpatient nurses, 1.2% inpatient healthcare assistants, 24.7% theatre nurses and 9.6% theatre operating department practitioners and healthcare assistants. The hospital told us they had reduced planned agency spend. The ward manager informed us agency was used approximately three to four times per month and two regular bank staff were used. Agency staff were not used in the day surgery unit as it was fast paced and staff required specific experience. The theatre manager said they used a cohort of regular agency. The theatre department was nearly at capacity with current activity but recruiting for posts in preparation for the theatre expansion.
- The hospital was recruiting to skills shortages in specialised areas such as ophthalmology and scrub nurses/practitioners.
- The central sterile services department was well staffed and had a supervisor to manage the team.
- The therapy team consisted of a physiotherapy lead, two physiotherapists and an assistant. The shifts were varied to ensure cover was provided and patients were managed for their inpatient discharge, to include working on a Saturday and Sunday.
- There was a well-documented training folder for all permanent and contracted staff. All contractors undertook a local induction and we were informed they were issued with a permit to work and well monitored when on site.

Surgical staffing

- Staff spoken with said surgical staffing was appropriate to ensure support was available to staff and patients were safe.
- There was 24 hours seven days a week consultant led care. Four consultant anaesthetists and four consultant orthopaedic surgeons were employed full time, the medical director operated as a general surgeon. Other consultants worked on the bank, to include the consultant anaesthetists and surgeons providing the lists for the local acute trust. Consultants providing the ophthalmology service were on the bank of an outsourced provider. Out of hours (overnight and weekends) there was a consultant for each speciality and anaesthetists on call cover to attend re-admissions and carry out emergency surgery if required. Staff informed us the first point of call would be the consultant anaesthetist and the on-call system worked well. Consultants had a 30 minute period to attend to the patient which they achieved.
- The resident medical officers were supplied by an agency. One resident medical was present on site 24 hours a day seven days a week and would escalate concerns immediately to the consultant on call. Resident medical officers had access to a clinical support helpline 24 hours a day seven days a week. We

identified from rotas there was a lack of continuity of resident medical officers, over a 14 week period from 28March 2016 to 3 July 2016 there were nine different resident medical officers on shift, each completing a one week shift. When speaking to staff they informed us how recently the resident medical officers had become more regular, resulting in a smaller number of resident medical officers on rotation.

- There was always an anaesthetist available to support staff. The anaesthetist was based in outpatients during working hours and acted as the resuscitation lead for the day and was therefore available for emergency situations and management of deteriorating patients in the ward.
- The consultant in the daily clinic would undertake the morning ward round for all inpatients; this included the resident medical officer.
- Handovers were completed between changing resident medical officers, a one to two hour allocated time was provided to complete this handover. Resident medical officers also attended nursing handovers in the morning and evening.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. Senior staff were aware of the hospital's major incident policy and how to access this.
- The hospital's risk register included if the supply of gas to the theatre fails. There was an escalation process in the event of this happening.
- Staff reported fire alarms were tested weekly and staff were aware of where and how to evacuate patients. Annual fire drills with staff were completed. Fire marshals were appointed.

Are surgery services effective?

Good

Overall, we have rated the effectiveness of the surgery service as good because:

- Care and treatment was provided effectively in line with evidence based guidance.
- Patients' pain relief was effectively reviewed and managed.
- The nutritional and hydration needs of patients was assessed and met.
- The hospital had processes in place to monitor and improve patient outcomes. To include enhanced recovery programmes.
- Staff were qualified, had skilled and were supported to complete their role effectively, they were provided with further training opportunities to improve competencies and enable personal development.
- Multidisciplinary team working was excellent throughout the surgery service.
- Support services for surgery were available 24 hours a day seven days a week with on-call arrangements out of hours.
- Information was readily available to staff to deliver effective care and treatment, and communication and relationships were maintained externally.
- Staff obtained patient consent throughout the patient pathway both written and verbal.

However:

- There was no formal documented handover in recovery which meant there was potential for staff to forget information which had been verbally relayed to them.

Evidence-based care and treatment

- Care was provided in line with guidance from the National Institute for Health and Care Excellence (NICE). Some examples included NICE QS49 for surgical site infections, NICE NG45 for pre-operative tests and NICE QS3 venous thromboembolism in adults. Staff provided examples of NICE guidelines followed in the hospital and they said they were notified of any new guidelines or Department of Health Central Alerting System (CAS) alerts at department or governance meetings.
- The head of nursing and clinical governance manager reviewed CAS alerts and NICE guidelines and would disseminate information to department managers. New guidelines which were applicable would be introduced and work processes and instructions updated accordingly. A CAS and NICE guidelines log was maintained and reviewed quarterly at clinical governance meetings. Alerts and guidance was a standard item on the agenda of clinical governance meetings. At the time of inspection new guidelines, NICE

QS123 home care for older people, was sent out to the ward manager who printed a copy to make available to staff. We saw evidence of email dissemination of a CAS alert to staff.

- The hospital followed guidelines for day case and short stay surgery approved by the British Association of Day Surgery (BADS) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Association of Perioperative Practice (AfPP guidelines). Sessions were planned for the next clinical governance day to reiterate to staff how the theatre runs in line with AfPP guidelines.
- Policies and procedures reflected evidence based care and treatment. Staff said they adhered to these policies and procedures and they were easily accessible electronically and also available as hard copies.
- When a patient received a blood transfusion a blood transfusion audit was completed to ensure standards were met. In February 2016 a patient received a blood transfusion and the audit showed 100% compliance with the standards.
- Patients had their needs assessed and their care planned and delivered in line with evidence based guidance, standards and best practice. Compliance was monitored through the hospital's audit programme. If audit compliance fell below 95% managers would complete an action plan. The fluid balance audit identified non-compliance on the ward due to incorrect adding on the chart. This was investigated and it appeared an agency nurse thought the fluid chart adding was the health care assistant's responsibility. Learning was shared to inform staff the registered nurses were responsible for the correct completion of the fluid balance chart. The ward manager checked all fluid balance charts for a period of three weeks to assure themselves they were being completed correctly and accurately.
- Professional guidance was followed by recording and managing implants in line with best practice. All patients who underwent joint replacement surgery consented to have their prosthesis registered on the National Joint Registry. This was done to contribute to the ongoing monitoring by the NHS on the performance of joint replacement implants, the effectiveness of different types and to improve clinical standards.
- We were informed corporate perioperative forums were held every couple of months and attended by the theatre manager to allow learning to be shared.

Pain relief

- Patients on the ward and day surgery unit told us their pain was well managed. One patient said they got pain relief when needed and within a reasonable timescale and all their pain relief medication was explained to them. As part of the discharge electronic patient feedback questionnaire patients were asked 'did the staff do all they could to help control any pain?', in March 2016 the results from 163 inpatients and day care patients showed pain was controlled for all 163 patients.
- Pain assessment was part of the parameters of the National Early Warning System (NEWS), if the observation revealed an unacceptable pain score then the patient was administered pain relief. Staff told us patient's pain was regularly monitored using the pain score scale of zero to 10, with zero being no pain and 10 being unbearable pain. One nurse told us they were looking to introduce smiley faces as a visual method for patients to identify their pain levels, this was discussed at the ward meeting and they were planning to implement. The multidisciplinary team were involved in monitoring pain, for example, the physiotherapists would liaise with the nursing team and resident medical officer to ensure pain levels were tolerable for exercises to be completed. Acute pain management protocols were available electronically. Staff said changes to pain management protocols have improved patient outcomes.
- There was no dedicated pain team however; the staff said they were looking to introduce a pain link nurse to communicate with the local acute trust pain team. The pain team from the local acute trust were booked to talk to staff at the next governance day.
- There were corporate pain management best practice guidelines available for staff to help them assess and manage pain effectively. Pain management training had also been provided in-house.
- The anaesthetist and resident medical officer completed a daily pain round. Pain was also discussed at the morning ward round.
- We observed a nursing handover where patient pain was discussed in detail to include their pain levels throughout the day and any pain relief they may require during the upcoming shift.
- Medicines which were only used when needed, called PRN medication, were prescribed for pain relief for patients.

- Patients were not transferred back to the ward from recovery unless their pain score was three or below. Pain audits were carried out quarterly and action plans devised as required. In February 2016 the pain audit score was 95% for 20 patients. For four patients their pain score did not remain at three and below following discharge from first stage recovery, action plans were put in place as a result of this finding.
- We observed good practice of administering pain relief in recovery. A patient became a little agitated; the nurse in charge immediately prepared and administered post-operative analgesia prescribed by the anaesthetist. In conjunction with reassurance to the patient, the patient settled quickly.
- Within the discharge pack patients received information on their pain relief they were provided with to take home. Staff recorded when the patient was last administered pain relief and when they were next able to take pain relief.
- Prior to admission patients received a pre-operative call where they were briefed to ensure they had an adequate supply of pain relief for when they returned home.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed. All patients had a nutrition screening question and full nutrition assessment using the Malnutrition Universal Screening Tool (MUST). This tool identified patient who were malnourished or at risk of malnutrition. Screening occurred pre-operatively, on admission and daily thereafter during an inpatient stay or as the patient's clinical condition changed. On review of three electronic records we confirmed the malnutrition universal screening tool was completed for inpatients. Every month the inpatient team undertook nutritional audits to ensure patients were screened within 24 hours of admission.
- We were told patients at risk of malnutrition were identified and a red tray system was initiated on the ward to highlight the patient had specific dietary needs. No patients were at risk of malnutrition at the time of our inspection.
- During the pre-operative phone call assessment the patient administrator informed the patient of their fasting instructions dependent on admission time. This included when and what patients could eat and drink. The individual fasting instructions were written on the theatre list which assisted staff in the event of calling patients to come in earlier or later. We were informed if an operation was delayed the nurses speak to the anaesthetist and fluid intake would be recorded on the medication record, diabetic patients could be cannulated to provide intravenous fluids.
- The patient administrator told us they would organise a theatre list to take in to account patient dietary needs, for example diabetic patients would be placed in the morning of the theatre list.
- Breakfast, lunch and dinner were provided to patients on the inpatient ward, and menus identified nutritional requirements. A small kitchen on the ward had a supply of snacks for patients. On our evening visit sandwiches were available in the fridge and crisps and biscuits were laid out on trays ready for patients to eat post-operatively.
- In the day surgery unit patients were provided with tea, coffees, biscuits and crisps. Cups of soup were also available. Following general anaesthetic patients were provided with sandwiches, if they had tonsillectomy or laparoscopic colectomy they were given toast.
- We observed jugs of water were full and within reach of patients on the wards, these were changed frequently, and patients were offered squash to encourage their drinking if they did not like water.
- During the nursing handover patient nutrition and hydration was discussed, to include any nausea and anti-emetics given. Patients who needed encouragement to drink were identified along with patients who had not eaten or had eaten small amounts. On observing the nursing handover it was raised two patients were not to be given any intravenous fluids as per the anaesthetists request as concerns of dilution. The cannula was blocked to prevent fluids being given.
- Staff told us dietary advice could be obtained from the dietetic department at the local acute trust; however this had never been required.
- Patients had to fulfil discharge criteria and were required to eat and drink prior to discharge.

Patient outcomes

- The hospital participated in the national Patient Reported Outcome Measures (PROMS) for knee and hip arthroplasty and groin hernias. PROMS are standardised, validated question sets that measure a

patient's perception of health, functional status and their health-related quality of life before and after surgery. The answers to these questions were submitted to a national data base which analysed the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The PROMS between April 2014 and March 2015 were within the expected range of the England average.

- The hospital did not have an Anaesthesia Clinical Services accreditation; however the medical director was reviewing options with input from the hospital's anaesthetic leads.
- There were 10 unplanned readmissions to surgery within 29 days of discharge between April 2015 and March 2016. This was good compared to other independent healthcare providers who have provided data to the CQC. There were no cases of unplanned returns to the operating theatre in the same reporting period.
- There were nine unplanned transfers of inpatients to other hospitals between April 2015 and March 2016, this is higher than average compared to a group of independent acute hospitals which submitted performance data to CQC. However, the hospital assesses and responds to patient risk to ensure safe practice. For example a patient suspected of a stroke following surgery was immediately transferred to the local acute trust.
- An agreement existed where local healthcare providers informed the hospital of any complications or concerns regarding patients treated at the hospital so action could be taken.
- Enhanced recovery programmes were followed to help improve patient outcomes. This was done through pre-operative assessments and planning and preparation before admission, immediate post-operative and peri-operative management to include pain relief and prophylaxis of nausea and vomiting, and early mobilisation.
- The physiotherapy team were involved throughout the patient pathway and the service was provided flexibly and based on meeting patient's individual needs. Patients were provided with pre-operative exercises to strengthen their muscles and post-operative exercises. For knee and hip patients staff aimed to mobilise patients the day following surgery and for them to use crutches by day two. Patients were provided with a full stair assessment before being discharged.
- The physiotherapy team contacted all hip replacement patients two weeks post operatively to review the patient's progress, those patients identified to not be reaching their mobility goals were invited back for review by the physiotherapy team. Knee patients were invited to a knee group help by the physiotherapy team, they would attend between two and five sessions once a week. Major arthroplasty patients were followed up at one year by the physiotherapy team to assess the improvement in quality of life. Any issues identified at this time would require referral back to the consultant.
- All patients received a post-discharge phone call between 24 and 72 hours (72 hours for ophthalmology) after discharge to review patient progress, provide support and record adverse outcomes. We listened to a post-operative call, this was competent and friendly, the call was recorded and findings reported to the resident medical officer, consultant or ward manager if there were issues. Advice and support was provided to the patient, the patient was asked about their pain, comfort, any problems and their general progress.
- Patient discharge advice was provided to patients to improve their outcomes to include information on managing their surgical wound, pain relief, thrombosis, and returning to their normal routine. Information for compression anti-embolism stockings was provided, to ensure the stockings were worn day and night for six weeks following discharge, to help prevent blood clots forming in the legs.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. Staff were required to complete competencies which were signed off.
- New staff said they received an induction to the hospital and induction policies were available which covered the responsibilities of the manager and the member of staff.
- A governance day was held monthly which was well attended by staff and allowed training to be provided and further learning and skills to maintain and improve the competencies of staff.
- A senior nurse or manager was on duty each shift to provide expert advice and support for less experienced staff both in theatre and on the ward and day surgery

unit. New staff were supernumerary until signed off as competent and were provided with mentors. Staff said it was a good working environment for students and new staff.

- All staff said they had received an annual appraisal and set goals which they aimed to achieve by the end of the year and were supported by management to do so. We saw two examples of appraisals using the performance discussion record completed for ward nursing staff. In October 2014 to September 2015 all inpatient and theatre department staff had received their appraisal. In the current year, 2016 all clinical staff in the inpatient and theatre department were up to date with their annual appraisal, 95% of other staff in the inpatient department had received an appraisal.
- Staff said they attended regular department meetings where they received group supervision and were able to discuss performance to ensure they were working competently.
- Revalidation training had been provided to nursing staff through a revalidation workshop. Staff said they felt supported for their upcoming revalidation.
- The 2015 annual staff survey showed only 51% of staff agreed where they work they had the opportunity for personal development and growth. However, when talking to staff during the inspection staff said they had access to lots of training opportunities to help them personally develop and to increase their competencies and therefore changes had been made since the survey results.
- Agency staff were required to complete an induction checklist to ensure they were competent. Managers said they escalate to the agency if the staff member was not appropriate. We reviewed agency checklists in both theatre and the ward. The ward manager reviewed all agency cv and held on file to evidence their competency and registration.
- Training for new equipment was always provided to staff to ensure they were competent in its use; recent examples included training for the new defibrillator provided by the resuscitation lead and an external representative providing training for the new syringe drivers. Training was also provided for blood pressure, electrocardiogram and ketone monitor machines.
- The resident medical officers were supplied by the agency who ensured relevant skills and training was provided. New resident medical officers at the hospital were provided with an induction and shadow for at least two days to include an anaesthetist check of their competencies before working alone on a shift. The anaesthetists supported the resident medical officers, particularly if busy. The resident medical officers were trained in advanced life support and one resident medical officer commented regular practice sessions were run at the hospital. The medical director had informed the outsourced provider when resident medical officers are not fit to work at the hospital, only competent resident medical officer's return.
- No consultants were operating under practising privileges at the time of our inspection. Consultants were employed by Care UK or were working under a bank contract. Appraisals were completed for employed consultants by Care UK. The appraisal process included a 360 degree review and a patient feedback questionnaire. We saw an example of a completed consultant surgeon appraisal which was very thorough. The hospital was 100% compliant for consultant appraisals. The revalidation process was facilitated and overseen by Care UK. All consultants working at the hospital were up to date with this process. For consultants on the bank the medical director was sent copies of their revalidation and appraisals. A monthly meeting attended by the medical director and the RMO team monitored fitness to practice issues including appraisal and revalidation status.
- Staff who were failing to achieve the required standard were supported by means of a developmental plan. There were formal policies to include the capability policy and probation policy. The human resources manager said they liked to see if they could help improve performance by offering opportunities in other departments more suited to an individual's skills.
- Additional training opportunities were provided to staff for example nursing staff were trained post operatively to mobilise patients and measure crutches so patients could be supported in their enhance recovery in the absence of a physiotherapist. A patient administrator told us they had been sent on a minute taking course.

Multidisciplinary working

- All staff commented on the excellent multidisciplinary team working within the hospital and all staff regardless of their role or level felt part of the team. Staff were complimentary about each other and valued each other's input to the team in order to provide effective care to patients. Numerous staff members were

extremely complimentary about the support they received within their department and the wider hospital. Staff said they could contact colleagues from other disciplines for advice when required. We observed good multidisciplinary team working across the different departments and highly positive relationships between staff during our inspection, this appeared very team based.

- Daily multi-disciplinary team ward rounds included the surgeon, anaesthetist, resident medical officer, nurse, physiotherapist and pharmacist. We observed one ward round which included nine staff members, although the ward round was consultant led the team worked together and were actively involved contributed to discussions. The anaesthetist was unable to attend the ward round and completed a separate pain round with the resident medical officer. The ward round was audited quarterly to ensure the team were 'doing it all' for the patient. Criteria included preparation prior to bedside visit, bedside visit and consultation, care planning, documentation and extended length of stay. In March 2016 100% compliance was achieved when auditing 12 patients.
- The nursing handover between shifts was also attended by the resident medical officer; any information from consultants, anaesthetists, theatre staff or physiotherapists was conveyed during the handover.
- We were informed the resident medical officer and nursing staff completed a ward round at approximately 10pm before the resident medical officer goes to their room. Once the resident medical officer had left they can be called for urgent needs. The ward manager asked staff to log when they called out a resident medical officer to allow this to be monitored to ensure they are not being called out unnecessarily.
- Staff told us the theatre department hold a morning board round at 7.30am which involved the multidisciplinary team and allowed the upcoming day to be discussed. Briefing prior to a theatre list and debriefing following a theatre list were attended by the theatre team, this gave staff the opportunity to provide feedback and rate the satisfaction of the theatre list. We observed records of briefings held by the theatre manager.
- Good team work was demonstrated in theatre, the patient was the whole focus of the team and all discussions were patient related. In the anaesthetic room the atmosphere was without tension, relaxed but professional and the patient and staff were clearly at ease.
- In recovery we observed a verbal handover from the consultant anaesthetist and the first assistant to two nurses in recovery. Two bank nurses were in attendance. The handover was supported in the patient's record. However approximately 15 minutes after the handover one of the recovery nurses was overheard asking the patient if they had a regional block. This information had been relayed during the handover; however with no template to record the handover verbal information can be forgotten.
- The resident medical officers said they felt very well supported and everyone was very approachable. They said consultant cover was appropriate and consultants could be contacted in and out of hours if needed.
- One nurse did say they have to adapt to different resident medical officers and it can be more difficult when new resident medical officers work or if they are less regular. However, nurses were very proactive and have adapted. This has allowed them to strengthen their skills. They would be confident to communicate with the resident medical officer and provide advice, and call the on-call consultant anaesthetist if they had any concerns.
- Good links were maintained corporately, for example every two months the orthopaedic clinical leads for Care UK met.
- Staff said they were able to contact and communicate well with GPs.

Seven-day services

- The hospital did not provide seven day surgery lists but provided medical and nursing treatment and care 24 hours a day seven days a week. Theatre sessions were run five or six days per week from 7am to 9pm based on patient schedules. Three theatre staff were always on the on-call duty rota should a readmission to surgery be required out of hours.
- The service was consultant-led, consultant presence in the hospital was evident during the day and they were on-call out of hours. The resident medical officer was available 24 hours seven days a week.
- There was a senior manager on call rota 24 hours a day seven days a week.

- Support clinical services to include pharmacy, diagnostic imaging, central sterile services department and pathology were provided 24 hours a day and seven days a week. On call support was provided by these teams out of hours.
- The hospital was covered 24 hours a day seven days a week by the estates team.

Access to information

- Staff said they were always able to access information they required for patients. Between January and March 2016 the hospital said there were no patients seen as inpatients or day cases without all their relevant medical records available.
- The hospital used an electronic patient record system and archived hard copy patient files on site. Two people could access the electronic patient record at any one time. Consultants were able to access the electronic patient records via password protection on external computers through a virtual private network. Staff said the electronic patient record was easy to access and use.
- An anaesthetist may request the patient's NHS record. This will be requested directly from the relevant acute trust. An appointment will be booked for the patient only once the notes have been received.
- For theatre lists run by the local acute trust the patient notes were requested prior to the theatre list date and it is checked to ensure the patient met Peninsula NHS Treatment Centre's eligibility criteria.
- The patient administrators aimed to ensure all information was present prior to the patient's surgery date. For example they checked if and where x-rays were done. They had access to the local acute trust information if this has been completed there. Pathology laboratory information could be accessed and results copied across to the patient's electronic record.
- We saw evidence of communication with the GPs to include sending an electronic copy of the discharge summary; this was sent immediately following discharge. A copy of the discharge summary was also given to the patient.
- Staff said they had a good relationship with patients' GPs and were able to contact them for information and likewise GPs could contact the hospital should they require information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff acted within the legal framework to obtain patient consent for treatment. Written consent was completed pre-operatively in the outpatient clinic and verbally checked again on admission and as part of the World Health Organisation (WHO) safe site surgery checklist. On admission we observed the consent being checked by the consultant with the patient and everything being explained to ensure the patient's understanding. The operating department practitioner also checked the operation with the patient and their consent. Consent was checked with the whole team present in the anaesthetic room and in theatre.
- We looked at 10 medical records and saw consent documents were fully and clearly completed.
- Patient consent was obtained for joint surgery. The National Joint Registry reviewed evidence that patients had consented for their personal information to be included on the national register. We saw evidence of this held where applicable on patient records.
- Staff were aware of their responsibilities to ask patients for consent for all activities and written consent required for invasive and surgical procedures.
- We observed staff obtain patient consent verbally for care and treatment throughout the patient pathway.
- Nursing staff had their competencies in mental capacity assessment assessed. Staff had a general understanding of the Mental Capacity Act 2005 and deprivation of liberty safeguards, however this was not regularly applied in the hospital due to the nature of patients and therefore knowledge was sometimes limited. Policy documents were available and staff would report any concerns to shift leaders or line managers.
- Staff understood the difference between lawful and unlawful restraint.

Are surgery services caring?

Outstanding ☆

Overall, we have rated caring of the surgery service as outstanding because:

- Patients were continually positive about the care they were provided while at Peninsula NHS Treatment Centre and this exceeded their expectations. We received

consistent praise about the hospital and all staff when talking to 10 patients in the ward or day surgery unit and reviewing 71 patient comment cards from patients who had received care in the hospital.

- We observed outstanding care being provided to patients by staff. All staff were highly motivated to provide person centred care which was dignified, kind, compassionate, respected and professional. This attitude was found in all staff, not just clinical or patient facing staff, but all supporting teams throughout the hospital.
- All staff took time to interact with patients. Patients were kept involved in their care and it was ensured they understood the care and treatment they were receiving. Relationships between staff, patients and those close to them were caring and supportive; this was encouraged by the hospital.
- Staff throughout the hospital put patient care at the forefront of everything they did. Staff showed an awareness of how they would recognise and respect people's cultural, social and religious needs, any preferences were reflected in how their care was delivered. This was evident in a specific example of care provided to a patient.
- Staff provided emotional support to patients, it was embedded in staff practice to value and identify emotional and social needs of patients.

Compassionate care

- Patients were treated with compassion and kindness. Staff were attentive to patients and respected them.
- We spoke to 10 patients who were all complimentary about the care they were receiving from all staff within the hospital, which exceeded their expectations. All patients agreed staff were compassionate and respected their privacy and dignity at all times. They said staff were always respectful. Comments included:
  - 'Brilliant, could not make it better, great experience'
  - 'The culture here is so different, they have time to care'
  - 'They all seem happy at work and nothing is too much bother for them'
  - 'It is 110%, can't fault the staff'
  - 'Staff are always smiling and polite, very kind'
  - 'Staff speak quietly to maintain confidentiality'
- One patient spoken with described how well they had been cared for in a previous admission in January 2016. They were entirely complimentary about all stages of their treatment, particularly the consultant and nursing care experienced, commenting how attentive staff were.
- Patients provided consistent positive feedback in the 71 comment cards received by patients who had received their care at the hospital. Comments relevant to compassionate care included:
  - 'They respect my dignity at all times and listen to me'
  - 'Treated with the greatest respect and dignity though the whole process…nothing was a bother'
  - 'Caring, dignifying and respecting'
  - 'Staff could not be more caring…treated in a dignified way'
  - 'Care is amazing…staff are professional yet caring and very friendly'
  - 'I am sure my recovery was enhanced because of the whole atmosphere evident'
  - 'Call bells answered promptly'
  - 'So thrilled to be able to come and have such a grand welcome and first class treatment'
  - 'Care is second to none'
- Twenty five patients contacted their local healthwatch to give feedback about the service at the hospital. Twenty three of these comments were highly positive. One patient said "the care is better than being at home"
- The friends and family test showed 98% of inpatients and 98% of day cases would recommend to their friends and family. There was an 87% response rate from inpatients and a 62% response rate from day care patients.
- The patient led assessment of the care environment audit results for the period February to June 2015 showed the hospital were better than the England average for patient privacy, dignity and well-being.
- In the annual staff survey 2015, 94% of staff said the care of their patients was the top priority and 91% said where they work goes the extra mile to provide quality care to patients. All staff felt confident that all members of the team were delivering compassionate care.
- Patients said staff responded quickly to call bells. We observed this response during our inspection.
- A professional and caring environment was observed in theatre, maintaining privacy and dignity throughout the

episode of care. In recovery, the senior nurse played a significant role in gaining the patient's confidence and had a soothing and calming influence, having a positive impact on recovery.

- We observed the care provided to a patient on admission to the day surgery unit, this was professional, relaxed, calm, unhurried and introductions were thorough.
- The consultant pulled the patient curtains during the ward round to ensure the patient's privacy and dignity was maintained. Staff also pulled curtains when helping patients to be washed on the inpatient ward. One exception observed was one instance when checking the mark site in the groin area of a patient sat in the day surgery unit, there was no curtain pulled around and there was another patient in the room. This was done discreetly with nothing revealed however privacy and dignity could be improved with the use of the curtains.
- On the inpatient ward we observed staff knocking on patient doors before entering. A please do not disturb sign was put on the door when the patient was receiving care from the nursing staff.
- Patients were walked to their car from the inpatient ward when being discharged. Staff said the patient is their responsibility until they are in the car. Patients were offered the opportunity to have their stockings removed and feet washed and patient fed back to staff that they enjoyed this very much. These examples demonstrate the attentiveness of staff with the safety and care of patients as their priority.
- One patient was transferred to the local acute hospital following an expected stroke in recovery. The consultant visited the patient at the local acute trust to check they were okay and to provide follow-up care.
- We observed a post-operative call to a discharged patient; the health care assistant demonstrated excellent people skills during the call, providing the patient with advice and support.

Understanding and involvement of patients and those close to them

- There was a strong, visible person centred culture. Staff built relationships with patients and those close to them to allow them to offer care and support and keep the patients involved throughout their care and treatment.
- Staff respected people's individual needs, and took in to account personal, cultural, social and religious needs. Leaders supported staff to go 'above and beyond' to meet the cultural needs of patients. We were given an example of how all staff were able to respond to a patient's religious and cultural needs to provide care the patient and their family were comfortable with.
- We observed staff ensured patients and those close to them understood the care and treatment they were receiving. We observed clear explanations being given to patients during the admission process, providing the patient with explanation of the effect of the procedure. Patient vital signs were monitored and the results were communicated to the patient in a manner they understood. Prior to theatre we observed clinicians, to include the consultant and anaesthetist thoroughly explain the procedure to the patient, and enabling the patient to have a voice and remain involved throughout their care and treatment. On the inpatient ward we observed a health care assistant explaining to a patient what they should expect to happen the following day. To include what observations and tests will completed and the time and what is for breakfast and lunch.
- One senior registered nurse said every day they keep the patient informed so they know what to expect and in this way they recover quicker. One member of the patient forum told us he was informed what level of recovery to expect for every stage of his post-operative care.
- Patients said they felt included in the treatment plan and were well informed. This included the consultant explaining the surgery events in detail to the patient and nurses talking patients through leaflets.
- Patients provided consistent positive feedback in the 71comment cards received by patients who had received care in the hospital. Comments relevant to a patients understanding and involvement included:
  - 'Explained everything in understandable detail'
  - 'The surgeon made time to talk to me before and afterwards….I did not feel part of a huge machine'
  - 'Staff at all levels were excellent, kind, caring and professional…..every procedure was explain to me along the way…questions always answered'
  - 'Excellent all round service – five star. Staff all amazing at all times. All questions answered straight away'
- We observed a ward round, during this ward round the consultant included the patient in discussions. They discussed their discharge arrangements. The consultant ensured care was available at home. The patients were asked if they had any questions.

Emotional support

- Emotional and social needs were assessed and recognised by staff and these were accommodated to ensure patients had support.
- When asked patients said they were provided with emotional support and staff were very kind.
- Patients provided consistent positive feedback in the 71 comment cards received by patients who had received care in the hospital. Comments included:
  - 'Anaesthetist put my mind at rest after listening to my concerns about pain'
  - 'The service was exemplary…level of kindness, care and empathy as well as clear information giving me reassurance'.
  - 'Staff made me feel calm'
  - 'Everyone was amazing, made me feel relaxed and helped with any issues, could not be happier'
- We observed a patient in theatre; staff were calm and supportive throughout the procedure. Staff recognised patient anxieties and provided reassurance to put the patient at ease.
- Staff commented they like being able to give care to patients as they have the time and resources. If a patient is upset or anxious they can spend time talking to the patients.
- There was no specific tool to screen patients for anxiety or depression once they were admitted to the ward. However, nurses described how they would consider all assessments made during the pre-operative clinic and would support a patient if they noticed they were anxious or depressed, discussing concerns with the resident medical officer and telephoning the GP as required.
- One staff member provided an example of a patient with a phobia of lifts and how they provided them with emotional support and accommodated their needs. Following the patient's hip replacement they underwent physiotherapy to allow the nurse to escort them up and down the stairs safely.
- The patient administrator provided an example of how they put a particularly nervous patient with one consultant. This was decided because the consultant had a particularly lovely manner with their patients and was extremely good at explaining everything to put a patient at ease.
- The clinical governance manager described how she had ensured that she had promptly visited the ward to speak face to face to a patient who had made a complaint because she recognised that the patient was experiencing post-operative depression. She was able to listen to provide reassurance to the patient.
- Counselling was available for patients through referral. The GP would be informed to follow the patient up in the community.

Are surgery services responsive?

Good

Overall, we have rated the responsiveness of the surgery service as good because:

- Services were planned around the needs of the local people. Feedback from the public was used to improve services.
- Patients were able to access care and treatment in a timely basis and where possible at a time to suit them.
- Individual patient needs were identified at their pre-operative assessment and where possible staff accommodated patient needs during their time in hospital.
- Complaints were handled appropriately and learning from complaints was shared.

Service planning and delivery to meet the needs of local people

- The hospital director met regularly with the clinical commissioning group and local healthcare providers to discuss the service plan. The hospital director commented how collaborative working is the key to the sustainability of the hospital.
- Theatre sessions were run five to six days a week from 7am to 9pm and allowed some flexibility and choice for the local population. Activity in theatres was planned and reviewed at weekly scheduling meetings. Theatre sessions were scheduled to meet the needs of the patient and activity with Saturday sessions. The patient administrator explained how they would look to see where patients lived and would put those who had further to travel later in the list to be considerate of the time it takes to get to the hospital. They also said the theatre lists would be arranged and take in to account

specific requirements, for example patients with a latex allergy would be first on the list, followed by diabetic patients on insulin. Patients with stoma bags would be placed last on the list.
- Staff were responsive in dealing with changes and delays. We observed delays being communicated to patients and apologies provided.
- Admission times were staggered to ensure the patient did not wait too long before their surgery, admission was generally one hour before planned surgery.
- Arrangements were made to ensure single sex accommodation on the ward and day surgery unit.
- On the inpatient ward relative visiting times were between 2pm and 8pm. A relatives and patients lounge was available to make hot drinks. Relatives of patients in the day surgery unit could use this lounge as they were not allowed in the day surgery unit due to crowding and to ensure single sex separation. There was a café available on site for relatives which served breakfast until 10am and lunch 11am-3pm.
- Parking on site was an issue for patients on busy days. As a result, parking off site for staff has been secured and further expansion was planned for the future.
- One patient on the comment card said 'Has been marvellous. Accommodating my diary conflicts when scheduling my procedure made it far more convenient'.

Access and flow

- We found that patients experienced a seamless flow throughout their patient journey with many patients not identifying a difference between their preassessment, surgery, and postoperative care.
- The hospital was meeting national indicators for waiting times of 18 week referral to treatment date between April 2015 and March 2016. This meant patients were beginning their treatment within 18 weeks of referral.
- Patients were referred to the hospital and following a clinical triage if the referral was appropriate the patient would be seen in the outpatient's clinic, following this appointment the patient was booked for theatre. On the day of surgery patients were admitted to the day surgery unit, they were taken to theatre for their surgery and following surgery to recovery. Should a day case patient not be well enough to be discharged there was capacity for them to be taken to the ward to remain in the hospital longer or for an overnight stay. The ward manager said they did not like to discharge patients later than 10pm. Following discharge patients were followed up post operatively.
- We were informed there had been 0% 'did not attend' meaning that no patients failed to turn up for their surgery when planned and staff were proud of this.
- One patient spoken with was complimentary about the efficiency of the surgical process during a previous admission. They were admitted at 9am, had surgery at 11am and were home by 3pm.
- Patients spoken with were happy with the access they had to their treatment. We were told they were able to come to hospital at a time suitable for them. One patient explained how they were able to defer their appointment to see a consultant of choice and another patient explained how they were able to cancel their own appointment and rebook at a more convenient time. One patient was on a cancellation list and had their surgery two weeks following their outpatient clinic.
- Theatre scheduling was completed by patient administrators. The theatre rotas were loaded a couple of months ahead and patients were booked accordingly, this was done by referral to treatment breach order and dependent on consultant availability. If a consultant required patients to be prioritised and seen more urgently this would be brought to the attention of the patient administrator. Patients were sent a letter with the date of surgery and once confirmed the date was suitable a time would be allocated. Patient administrators demonstrated a knowledge of what was required for lists, for example placing patients with latex allergy at the start of the lists, an understanding of surgical kits and turnaround times, and where possible grouping ophthalmology patients in to right eyes and left eyes.
- Patients could request to be on a cancellation list. We were informed there were approximately 10-20 patients on each consultant's cancellation list. Patients on a cancellation list were given first choice, in the event these patients were unable to attend patients would be phoned to bring forward their surgery date. The patient administrator told us they tend to fill all cancelled slots.
- Patients were phoned five working days before their admission date to confirm the time and ensure they had the appropriate information prior to their surgery. This

was recorded on the electronic patient record. Patient administrators said they manage patient expectations where possible by informing them where they are on the list and the potential for delays to arise.

- Patients would be cancelled if they were unwell or had been on antibiotics. They were also cancelled if they had pressure ulcers. The hospital aimed to minimise any cancellations by checking information with the patient at the pre-operative assessment in outpatients and during the pre-operative call, patients were asked to alert the hospital of any changes prior to the surgery date.
- Admission was staggered; patients normally arrived one hour before their surgery time (30 minutes for ophthalmology patients). Patient administrators ensure the admission time and surgery time told to patients is recorded on the theatre list.
- The hospital recognised inefficiencies in the utilisation of theatre sessions, for example late starts, early finishes and prolonged turnaround times. This posed challenges to the staff and could increase the patient wait for an appointment. An electronic system was used to monitor the efficiencies and turnaround times in theatre. The procedure start was recorded, beginning with the anaesthetic WHO surgical safety checks and ended when the patient left theatre to go in to recovery. The hospital's aim was for a 10 minute turnaround in theatre before the next patient. The theatre utilisation tool allowed late starts, delayed turnarounds and early finishes to be monitored. It also monitored outside of operating hours of a session to capture early starts and late finishes. The theatre manager told us they aimed for 85-90% utilisation. The week prior to our inspection there was an 80% utilisation, the drop in utilisation was due to an emergency transfer of a patient which caused delays in theatre. Theatre utilisation reports were completed weekly and reviewed at scheduling meetings. If trends were identified an action could be taken, if required this could be escalated to governance for further review.
- Delays in theatre would be communicated to patients who were waiting in the day surgery unit. There was also scope for patients at home to be contacted to delay their admission time. Any cancellations would be explained to the patient and an apology provided, the patient would be rebooked as soon as possible.
- Between April 2015 and March 2016 there were 37 procedures cancelled for a non-clinical reason. All 37 patients were offered another appointment within 28 days. During our inspection one patient had been cancelled near the end of the theatre list because the theatre was too hot. Maintenance was called to repair the problem. The surgeon spoke to the patient to explain why they were cancelling the appointment. The patient was rebooked for two days later. The estates team told us they do everything they possibly can to prevent cancellation of theatre lists due to maintenance or equipment failures.
- The orthopaedic enhanced recovery pathway was following an average length of stay of less than 3 days and most patients were discharged by day three. Mobilisation of patients, where clinically possible, began on the day of surgery.
- We observed a patient being discharged from the day surgery unit. There was involvement of both the physiotherapist and the nurse prior to the discharge. A discharge checklist was completed and clinical outcomes discussed. The patient was provided with a comprehensive discharge pack.
- Prescription waiting times were audited to monitor any delays to discharge. For one week in May 2016 covering 45 patients the average waiting time from prescription being put in to pharmacy and the prescription being handed out was 10.2 minutes, the few delays seen with the waiting time was recorded as computer issues or a pharmacist being on the ward round.
- Following discharge patients had access to a 24 hour patient helpline. All calls to the helpline were documented and reviewed to identify trends and actions as required. The phone was held by the medical secretaries between 8pm and 5pm, the resident medical officer between 5pm and 11pm, and the ward nurses between 11pm and 8am. Messages could be taken and an appropriate clinician would phone the patient back.
- Patients received a post-operative call within 24 hours of discharge (72 hours for ophthalmology patients). The call was recorded on the electronic patient record using a checklist. We saw evidence of this completed on three electronic patient records and observed nursing assistants phoning discharged patients during our inspection.
- On the day of our inspection one patient arrived with a letter confirming operation was that date. The patient was not on the list and an apology was provided to the

patient. The patient was fitted in to the list for the operation to be performed. Staff informed us an investigation would be completed as to why the appointment letter and list did not match up.

Meeting people's individual needs

- A patient's individual needs were established at referral or during the pre-operative assessment in outpatients to allow for the staff in the hospital to make arrangements to accommodate, where possible, individual needs during a patient's admission, surgery and inpatient stay.
- All staff received equality and diversity training and therefore had an understanding of meeting the needs of different people. Equality and diversity link nurses were present in the hospital. At a corporate level, Care UK had prepared an action plan to meet the requirements of the Public Sector Equality Duty Act but this was not yet made specific to the Peninsula NHS Treatment Centre location.
- We were provided with an example of how ward and theatre staff accommodated the cultural and religious needs of a patient. The hospital was highly responsive to the patient's dietary and privacy needs.
- The environment enabled wheelchair access, doors were wide, and lifts were available for use.
- The hospital had recently made access to Wi-Fi available for patients. This allowed patients to communicate with family and friends while in hospital.
- A varied menu had meals to accommodate individual needs to include; suitable for diabetics, low fat, low calorie, moderate salt, gluten free, vegetarian, soft food and healthy option. Patients said they were happy with the food provided and snacks were available outside of meal times should they still be hungry. Patients were provided with regular hot drinks and water jugs were changed three times a day with the option of flavourings for their water.
- The hospital treated very few patients living with advanced dementia due to the surgical exclusion criteria. Nevertheless, a dementia strategy was in place and there was an allocated dementia friendly room. We observed the dementia friendly room which had dark blue walls and a big clock face; there were no changes in the toilet area. The room had two beds to allow carers to stay with the patient should it be required. Carers were provided with a carer's passport to allow them to visit the patient at any time. One staff member had a dementia lead role, they attended local dementia conferences. Nine members of senior staff across the hospital had completed formal dementia training. A dementia file was available on the ward to provide education and information leaflets to staff. If patients were suspected of dementia during their time in the hospital, staff said they would refer patients to the memory service or contact their GP for further assessments to be completed.
- Staff informed us patients with learning disabilities were accommodated. Similarly to patients living with dementia, carers could arrange to stay with the patient and carer's passports were provided to enable visiting at all times. Staff explained how this was recently arranged for a carer to stay; the carer was allowed in anaesthetic room and was there when patient woke up. Exceptions would be made and the relative would be allowed in day surgery unit, using curtains to maintain privacy and dignity and comply with the single sex arrangements.
- Access to translators was available. An example was provided of this arrangement being in place for the week following our inspection.
- One nurse had completed the British Sign Language course; this was requested by the nurse and funded by the hospital. The nurse had taught other staff basic sign language. Staff said one hearing impaired patient who attended the hospital recently was thrilled a staff member could communicate with them.
- A patient's emotional well-being was checked at the pre-operative nursing assessment completing their emotional and cognitive state. Alerts would then be put on the electronic patient record so staff were aware. Staff said they would use the alert to be aware of a patient's individual needs and respond accordingly. Anxious patients could have someone to stay in their room. Depending on a patient's emotional state during the inpatient stay staff could contact the GP if they felt a patient needed additional support following discharge.
- One member of staff identified that the arm chairs were not appropriate for hip and knee patients, and they were planning to suggest this to the ward manager.

Learning from complaints and concerns

- The hospital had policies and processes in place to appropriately investigate, monitor and evaluate patient's complaints. An acknowledgement of the complaint was provided within three working days and a full response provided within 20 working days.

Outstanding ☆

Surgery

- Between April 2015 and March 2016, 22 complaints for the whole hospital were received. The rate of complaints per 100 discharges was lower than average. One complaint was referred to the ombudsman. The clinical governance manager was responsible for investigating complaints supported by relevant members of the senior management team. We reviewed the complaints log and between December 2015 and March 2016 five complaints were received. All were acknowledged and responded to in a timely manner. Action plans were initiated and actioned following complaints.
- How to make a complaint leaflets and patient advice and liaison literature was available in the inpatient ward and day surgery unit. Have your say card for NHS choices was provided to patients in their discharge pack.
- Complaints were discussed at senior level and formed part of the quality governance meetings, learning was shared with the multidisciplinary team. Staff said they were informed of any complaints and learning from complaints.
- One example of how a change was made was following a complaint from a patient discharged home after a hip replacement. The patient stated they were unaware of the extent of bruising that may occur after discharge. Following this a leaflet was added to the discharge pack of all hip replacement patients with the required information on post-operative bruising.
- A complaint was received about the coffee shop closing at weekends, so developed a coffee corner for access to visitors and patients to help themselves when unattended.
- None of the patients we spoke with during the inspection had any complaints about the service. Four minor issues were raised, amongst positive feedback on the 71 patient comment cards from patients who had received care in the hospital, this included:

- 'Not made aware of the two hour wait'
- 'Only niggle I was told to stop my hormone replacement therapy…told later this was unnecessary…caused me discomfort afterwards'
- 'Only complaint was that my lip was split and swollen after breathing tube removed'
- 'Food could be improved'

Are surgery services well-led?

Outstanding ☆

Overall, we have rated well-led of the surgery service as outstanding because:

- The leadership, management and governance of the surgery service consistently assured the delivery of high-quality person-centred care.
- There was a clear corporate vision and strategy and staff were able to repeat this and understood their responsibilities to achieve the vision for the hospital.
- The management team built relationships with other organisations and worked together to enable the hospital achieve their vision and strategy to deliver quality care to patients and improve outcomes.
- There were clear governance arrangements in place which reflected best practice and were managed proactively. All staff were encouraged to attend the monthly quality governance meetings and were actively engaged in the hospital's governance processes.
- Senior staff understood the key risk management issues. Live risk registers were maintained and reviewed regularly.
- An extensive audit programme was used to monitor the hospital's performance and quality of care, clear action plans were put in place if non-compliance was identified and learning was shared.
- There was a strong local leadership, the senior management team were visible, approachable and supportive, and motivated and inspired all staff.
- There were high levels of staff satisfaction across all equality groups. Staff were extremely proud of the hospital as a place to work and spoke highly of the culture. Staff felt empowered, actively engaged and were encouraged to raise concerns.
- We saw strong collaboration and support across the different departments and staff roles. Patient experience was everyone's responsibility.
- The management team supported learning and innovation.
- Staff said there was an open and fair culture.
- Positive and negative feedback from people who use the service was actively sought and valued. This was used constructively to make improvements to the service.

Outstanding ☆

Surgery

Vision and strategy for this this core service

- The senior management team told us their vision for the hospital was to be the region's leading independent provider for NHS elective care by delivering care to the highest standards of quality and best practice whilst meeting and exceeding all relevant standards across the healthcare sector. When talking to senior management, patients and staff were at the centre of everything they did.
- The hospital embraced the corporate values which included; customers being at the heart of everything they do, everyone making a difference and together they make things better. Staff had knowledge of the corporate values and understood their responsibilities to ensure this was achieved and embedded in their practice. Staff said these values were based on the six Cs of nursing; care, compassion, courage, communication, commitment and competence.
- Plans were in place for an extra theatre and an endoscopy suite which the hospital was aiming to begin building in November 2016. The theatre manager told us this will improve flow through the theatre department. Increased capacity will allow all three theatres to be operational Monday to Friday, with no late shifts. The hospital director said the strategy for the next six months was focussed on ensuring there was sufficient staff for this expansion as well as the current remit.
- The surgery service had set challenging but achievable objectives for future development including a plan to increase the type of surgery offered, to include simple spinal surgery and simple colorectal surgery. The medical director confirmed they would ensure the new services were introduced safely. For example, spinal surgeons from the local NHS acute trust had attended governance days to educate staff on spinal surgery and shadowing opportunities at the local NHS acute trust would be made available for consultant anaesthetists.
- There was a corporate vision for collaborative working. The hospital demonstrated how they worked with other organisations to help improve their outcomes and deliver a service for the benefit of the patient. For example, good working relationships corporately, with clinical commissioning groups and the local NHS acute trust. The management team said they had built strong relationships and as a result there were safer environments for the patients.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework to support the delivery of the service and good quality care. The arrangements were based on best practice and person-centred care. All staff across the hospital, regardless of seniority, were involved in achieving good hospital governance. Staff said there was a excellent feedback system within the hospital to allow governance issues and information to be cascaded. Staff had an understanding of their own and their colleague's roles and responsibilities for good governance.
- Clinical governance meetings were held monthly. Meeting minutes showed each department was considered and discussed. Meetings were attended by the hospital management team, department managers and consultants. All staff were invited and encouraged to attend these meetings. We saw evidence in meeting minutes of ward and theatre staff attendance at the clinical governance meetings.
- A governance month end report was produced and discussed at the clinical governance meetings which reported on quality measures to include; unplanned transfers, unplanned re-admission, clinical and non-clinical cancellations and whether they were avoidable or unavoidable, conversion to inpatient stay from a day case, patient falls, incidents, venous thromboembolism and patient satisfaction.
- Any issues identified within the hospital were escalated to the governance team for further investigation. For example a physiotherapy team follow-up call identified a patient had been to the local acute trust with a urinary tract infection, the physiotherapist informed the governance team to allow them to investigate. The governance team requested the medical records from the local acute trust and at the time of our inspection an investigation was underway.
- Weekly communication meetings were held with all heads of department and clinical leads, chaired by the hospital director. Monthly heads of department meetings were chaired by the hospital director, the agenda included any matters arising, hospital director update, human resources, clinical report, finance, marketing, health and safety and departmental reports. These meetings enabled efficient communication to heads of department and clinical leads.

- Senior staff and management attended weekly scheduling meetings. They reviewed the previous week's activity and had a forward view of the planned theatre activity for the following four weeks.
- Staff at all levels were actively encouraged to raise concerns. The ward and theatre held monthly departmental meetings to allow for staff to be kept informed and any issues to be discussed. We saw examples of meeting minutes. Staff said issues discussed at department meetings were actioned. For example it was raised that minor day cases were better to be placed at the start of the theatre list to avoid discharge delays. The departments also had communication books to allow for staff to be updated of changes or information outside of the monthly meetings.
- There were no consultants working under practising privileges at the time of our inspection, and this was not intended to be reintroduced to the hospital processes.
- There was no Medical Advisory Committee (MAC). In independent hospitals the MAC acts as an expert advisory group and supports hospitals in monitoring safe, effective and responsive care. At the Peninsula NHS Treatment centre, this function was met by various forums at corporate and local level.
- Issues relating to clinical practice were comprehensively discussed at several alternative forums at corporate level. The hospital director attended the three monthly clinical and governance assurance committee to discuss issues such as antibiotic stewardship and a recent anaesthesia clinical audit. The hospital director and medical director attended the three monthly corporate hospital director and medical director meeting to discuss issues such as the impact of clinical guidelines as well as operational protocols. The lead anaesthetist attended a three monthly corporate anaesthetic leads meeting to discuss recent root cause analyses of incidents and shared learning. The clinical governance manager and the head of nursing and clinical services manager attended a three monthly secondary care professional leads meeting to discuss issues such as shared learning from never events.
- The medical director was responsible for reviewing clinical work undertaken at the hospital and ensuring consultants were competent to work. The medical director was part of the hospital's management team and had a good working relationship with the consultants to ensure medical issues were reviewed regularly and changes made accordingly. All employed consultants attended the clinical governance meetings and any changes to practice would be discussed at this forum, for example trialling of new implants. The orthopaedic consultant surgeons held a monthly meeting. This gave the consultants an opportunity to discuss agreed practice and protocols in line with evidence based guidelines, for example post-operative x-ray protocol. The anaesthetics team attended a monthly meeting to discuss new policies such as antibiotic policies and present clinical cases and consider best practice to support vulnerable patients. This included consulting with experts at the local acute hospital regarding management of patients with anaemia.
- Quality governance days were held monthly which were compulsory for all staff. During these governance days, staff attended department and hospital wide meetings with opportunities to undertake training sessions. This ensured all staff were up to date with their training and fully informed about hospital activities and challenges. There was no clinical activity other than inpatient care on these days. Staff said this was a great opportunity to be provided with updates and improve competencies and understanding through training offered.
- Arrangements were in place to identify record and manage risks. The clinical governance manager was responsible for the hospital's main risk register and this was taken to clinical governance meetings. The hospital risk register was a live document and risks would be placed on the register and removed once they were resolved. For example the faulty anaesthetic machines were placed on the risk register, and were withdrawn following purchase of the new machines. At the time of inspection there were eight risks on the risk register which were being actively managed. High risks were escalated to the corporate board for immediate action.
- Departmental risk registers were managed by the head of department, deputy head of department and health and safety representative. At the time of inspection the day surgery unit included six amber risks, the ward included two red, three amber and one green risk and theatre included one red, 11 amber and two green risks. Actions taken and review dates were included on the departmental risk registers. Risk assessments and safe systems of work were also completed at departmental level.

- An extensive and proactive audit programme was in place to measure the quality of the services provided by the hospital and within the surgery service. Audits were completed in both the theatre and ward department. If audits scored below 95% they were identified as non-compliant and an action plan was put in place. Department managers had a good awareness of the areas identified for improvement within the audits and demonstrated how learning was shared.

Leadership of service

- There was a strong local leadership focused on delivering high quality care. Leaders had skills, knowledge and experience and inspired and motivated staff. Managers were sent on management courses. Staff said leaders were visible, approachable and supportive. They regularly visit the departments to say hello to staff and provide staff the opportunity to talk to them to celebrate success or to raise any issues or concerns. Pictures of the leadership team and consultants were on display in the café area for patients and relatives to identify.
- Staff were positive about their leadership team. Comments included:
- 'The leadership is brilliant, I feel very supported, and they encourage us to thrive'
- 'The theatre manager understands and is the best thing'
- 'We are well supported by the executive team'
- 'The executive team are 100% behind you and implement things'
- 'The hospital director can enforce change and put an appropriate case in place'
- 'There is always an open door'
- We spoke with eight staff who predominantly worked night shifts and they all said they felt well supported despite working out of hours. There was a communication book that allowed all staff working night shifts to be kept informed. For nursing staff that were working a night shift it was ensured the following month they were not on a night shift to allow them to attend the next governance day. Night time cleaning staff were kept informed of the theatre managers shift pattern so they could contact the manager or arrange a meeting. These staff were encouraged to attend alternate governance days and their shift patterns were organised to accommodate this.
- Department managers had good knowledge of their staff and their objectives and individual needs. All staff were highly complementary about their immediate leaders. One comment included managers bent backwards to support staff. One comment card from a staff member said their 'theatre manager has been proactive…change for the better, manager is supportive, positive and the door is always open'.
- Department managers said they were well supported by the leadership team and their staffing needs were well supported. Senior managers felt well supported by their colleagues in the leadership team and by the managers at corporate level.

Culture within the service

- There was strong collaborative working and support across the departments of the surgery service and throughout the hospital. All staff had a common focus of delivering high quality care and patient experience.
- Staff said the culture encouraged candour, openness and honesty. They felt respected and valued, by patients, colleagues and management. Staff were confident action would be taken by the hospital to address staff behaviour and performance if inconsistent with values, regardless of seniority.
- There were high levels of staff satisfaction across all departments and job roles. Staff were eager to share with us how much they enjoyed working at the hospital and were very proud of how the hospital worked together to deliver great care for patients. Staff spoke very highly of the culture. Comments from staff included:
- 'Great place to work, great atmosphere'
- 'Proud to be here'
- 'I feel very valued and I have been told by the executive team the value of my work'
- 'Good team dynamics in theatre are really something to celebrate'
- 'Clinical governance day brings the team together and allows staff to receive training'
- 'I am treated as a person, it feels like a family'
- 'Extra special place to work, you get more time to spend with patients and can get the best out of the patients. Time, space and resources are available and can build good relationships.'
- 'Can talk to all staff on a first name basis not just Mr'
- 'Organised, well run, friendly, planned hospital'
- 'I worked as a nurse for 20 years and this is the best place I have ever worked. Care UK invests in training and promotes best practice'

- 'I enjoy coming to work…every staff member down to cleaners up to consultant respect one another…treatment patients receives is five star and safe'
- When staff were asked what could be better most staff had to really think about this question and were unable to provide improvements.
- The hospital described itself as a learning organisation. Staff said there were good training opportunities which allowed them to develop personally. Staff were encouraged to move between departments to progress their career, for example a staff member who previously worked in the hospital's coffee shop and was encouraged and supported to become a healthcare assistant.
- A number of staff, including administrators and housekeepers said how they were provided with the opportunity to observe in theatre to allow them to have an understanding of the whole patient pathway.
- Events were held by the hospital to include quiz nights, charity 'children in need' days and charity book sales. This allowed staff to come together.
- The turnover of staff in the ward and theatre was monitored on a monthly basis, for June 2016 it was at 17.6%. Sickness for June 2016 was 1.02%.

Staff engagement

- Staff said they felt actively engaged and their views and experiences were gathered and acted on. They felt the hospital valued staff raising concerns and they had openness so concerns raised were actioned. They were encouraged and acted upon.
- Staff were encouraged to take on additional roles within the hospital, link nurses were in place in both the ward and theatre department. Staff with particular interests were able to take on these roles to develop their own practice and ensure the hospital was working to best practice guidelines.
- A hospital newsletter was produced approximately every other month to ensure staff engagement.
- The hospital aimed to hold monthly staff forums; we saw evidence of meeting minutes.
- Regular staff engagement meetings were open to the whole unit and were well received.
- Staff completed an annual 'over to you' survey. The analysis of the feedback forms the basis of the following year's 'over to you' strategy. Staff said this survey remained anonymous and they felt action had been taken where possible for any issues they had raised.
- Nursing resources were available on the ward to include books and the nursing journals which was bought by the ward manager and shared with staff.
- Corporately staff success was celebrated within the annual health care awards whereby 14 categories were available for staff to be nominated. One health care assistant at Peninsula Treatment Centre won the award for the top care assistant in the 2015 health care awards.
- Thank you cards were on display throughout the hospital to remind staff of their successes. Cards were scanned and sent to all staff. If the card included a staff members name it could be used for their revalidation.
- Staff said they felt constructively engaged when asked to complete and review standard operating procedures, we were told these procedures were clear to staff as they were created by the people who needed to follow them.

Public and patient engagement

- The hospital welcomed feedback from patients to allow improvements to the service to be made. The hospital said they valued patient feedback and where practically possible they put in place the suggestions to allow improvements. A 'you said we did' board was displayed on the inpatient ward. This first issue raised was waiting times on admission, as a result staggered admission times were introduced. A second issue raised was relatives having to wait, so as a result the family lounge was available for relatives and provided tea and coffee facilities. The third issue raised the theatre corridor and inpatient ward was tired and shabby, so the hospital was in the process of repainting walls and putting up colourful artwork.
- The hospital had a patient forum which met every six months. This forum was attended by patient representatives plus the hospital director and various members of the senior management team such as the head of nursing and clinical services, patient services manager and clinical governance manager. Forum members were encouraged to provide their opinion on matters relating to the development of services. For example, the forum was consulted regarding the introduction of a patient nominated annual award for

staff, and the introduction of 'black box' recording in theatres. Patient forum members acted as patient ambassadors who were available to talk to new patients who might feel anxious about a future stay at the hospital. Two members of the forum had completed a patient led assessment of the care environment audit. Following the audit minor changes to signage had been implemented in the refurbishment of some public areas. The group had previously been patients and continued to advertise for further forum members. The patient forum members felt involved and part of the hospital. The forum provided valuable feedback on patient experience to the hospital to allow the services to be planned to meet the needs of the local people. Patients on the forum said they were able to raise and ask questions to provide challenge.

- Patients were invited to share their experiences at quality governance meetings. We saw an example in the May 2016 meeting minutes where a patient attended to share their experience following a right hip replacement and a left knee replacement.
- A hospital Facebook page allowed patients to provide their feedback via social media.
- A recent survey from patients suggested outside areas of the hospital could be made more attractive. As a result a green team was created, made up of staff volunteers. The health and safety environment co-ordinator, who was a physiotherapist and leading on the initiative, told us they were looking to improve the local environment and aiming to get patients involved. They had plans to grow plants and herbs in the garden, involving discharged patients, which would have post-operative benefits. They were empowered and supported by the hospital to take this forward to improve the quality of care and people's experiences. This had been put forward as a possible model of care for other Care UK organisations.

Innovation, improvement and sustainability

- A clinical transformation project was used to improve the patient pathway by ensuring clinical operational excellence. It helped improve services in theatres by monitoring theatre utilisation, making them as effective as possible.
- All of the scrub team were booked to attend first assistant training, funded by the hospital. The theatre manager said this will enable flexibility in the theatre department.
- The green team met monthly to discuss improvements, this was a voluntary team. They had looked at waste segregation and waste output. Changes made included a recycling scheme, the way clinical waste was managed and updated fire training and local action plans and the input of fire wardens. The green team planned to continue their innovation and improvement of the hospital to ensure its sustainability.
- The estates manager had been looking into ways in which to save the hospital money by means of changing all of the light bulbs to LED lighting. In turn this reduced the carbon footprint through voltage optimisation with a 20% cost reduction. There was monthly monitoring of all water and electricity usage in order to demonstrate areas where savings could be made.
- A weekly vacancy report was produced and discussed with human resources. A recruitment strategy had been developed. This included return to practice agreement with the local university and development of a preceptorship programme for newly qualified staff. The hospital said they worked with the local university and had good success with nurses.

Outstanding ☆

Outpatients and diagnostic imaging

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

Information about the service

Peninsula NHS Treatment Centre provided outpatient and diagnostic imaging services that included general, mobile and theatre radiology to NHS patients. The magnetic resonance imaging (MRI), ultrasound and computed tomography (CT) was outsourced to a local acute NHS hospital. The hospital did not treat children and young people because of strict eligibility.

Patients attended consultant run outpatient clinics for pre-operative assessments and follow-ups post-operatively. The outpatient department had four consulting rooms. Clinics were held daily Monday to Friday and included specialities for orthopaedics, ears nose and throat, general surgery and ophthalmology. The physiotherapy team worked closely with patients in the outpatient department.

There had been 7,473 adult outpatient appointments for the period from April 2015 to March 2016. The appointments were divided into first attendances (3,906) and follow-ups (3,567) for NHS funded patients. The diagnostic imaging department X-rayed between 20-25 patients a day.

During our inspection we visited the outpatients department where clinics were being held, the main X-ray department, and the physiotherapy department. We spoke with staff including the outpatient manager, nurses, consultant surgeons, physiotherapists, radiographers and the provider's radiation protection advisor (RPA). We also met with the management team including the hospital director, medical director, head of nursing and clinical services. We met with six patients and also met with three members of the patient forum and obtained patient feedback through 71 comment cards. We observed care and looked at records and data.

Outstanding ☆

Outpatients and diagnostic imaging

Summary of findings

Outpatient and diagnostic services at Peninsula NHS Treatment Centre were rated as outstanding overall.

We found:

- There was a strong culture of incident reporting, with no serious incidents reported in the last year, and the department was clean with good infection prevention controls in place.
- There was a good understanding of safeguarding by staff who were trained in line with national standard and could describe how to escalate any concerns.
- The use of best practice was evident throughout the outpatients and diagnostic imaging department. The hospital used national surveys to capture patient outcomes.
- Multidisciplinary team working was evident throughout the department and diagnostic imaging and physiotherapy was available to inpatients seven days per week.
- Staff demonstrated an understanding of consent and decision making requirements of legislation and guidance.
- Care was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance. There was an embedded patient centred culture, and staff demonstrated genuine compassion for patients and their families.
- Consistent positive feedback was provided by patients, which demonstrated high levels of satisfaction of the outstanding care which was being provided. Staff provided emotional support to patients, identifying anxieties and responding to ensure the patients were at ease.
- Staff identified patients with specific cultural needs and ensured the inpatients teams were aware of these requirements.
- The hospital was meeting its referral targets and most patients were seen within six weeks of their referral.
- Patients could access care and treatment with a choice of appointments offered to suit them, and care and treatment was only cancelled or delayed when necessary.
- Arrangements to support patients with learning difficulties were in place, such as extra time for appointments and visits to the ward prior to admission.
- There had been no formal complaints regarding outpatients or diagnostic imaging in April 2016 to March 2016.
- The leadership, management and governance of the hospital assured the delivery of high-quality person-centred care. There were clear governance arrangements in place which reflected best practice and were managed proactively.
- All staff were encouraged to attend the monthly quality governance meetings and were actively engaged in the hospital's governance processes. This promoted a learning culture across and within the hospital teams.
- Staff at all levels said information was always cascaded to keep them well informed.
- Feedback from staff was consistently positive about department and senior managers. The senior management team were visible, approachable and supportive.
- There was an excellent working culture within the department, which was patient focused and interactions with patients were positive. Staff were encouraged to identify ways to improve the service for patients and were empowered to make changes themselves.

However, we found:

- Out of date medicines were found in one consulting room.
- Non-compliant flooring in the consulting rooms that had not been risk assessed.
- Signage was not adapted to aid the vision of patients with impaired vision.

Outstanding ☆

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

Overall, we have rated the safety of the outpatient and diagnostic service as good because:

- There was a strong culture of incident reporting, with no serious incidents reported in the last year.
- The department was clean and had good infection prevention controls in place. Cleaning audits showed 100% compliance in the outpatient and diagnostic areas.
- Patients' records were generated and stored electronically so they were easily accessible.
- There was a good understanding of safeguarding by staff who were trained and could describe how to escalate any concerns.
- Staffing levels were good, with low sickness levels and vacancy rates.

However:

- Two consulting rooms were found to be non-compliant where there were no risk assessments about the lack of coved skirting boards, which prevent the accumulation of dust and dirt.
- We found two drugs in a consulting room that expired prior to the date of our inspection.

Incidents

- Staff were open, transparent and honest about reporting incidents. There were systems to make sure incidents were reported and investigated in line with the hospital policy. All staff said they would have no hesitation in reporting incidents to managers and knew how to report them through the electronic system. All staff received training in incident reporting.
- Electronic systems were used to report all incidents. Clinical managers reviewed each incident and investigated where necessary. All incidents were discussed at monthly quality governance assurance meetings, and learning from all incidents was cascaded down to staff. Learning themes were shared during the monthly staff meetings. Staff said they were provided with feedback on incidents, and they were well supported when incidents occurred.
- There had been no serious incidents affecting patients in the outpatient, diagnostic imaging or physiotherapy departments in the last year. There had been no minor incidents reported in the outpatient department and two minor incidents relating to diagnostic imaging in the period January to May 2016. Two minor incidents related to a misinterpreted X-ray request form and a cable that had become dislodged from a piece of software. Staff rectified these incidents in a timely and in a considered manner and patients were not at risk of harm.
- There had been no recorded incidents requiring external reporting within radiology from April 2015 to March 2016. Providers 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 CQC.
- There was clear information in place to clarify the process for reporting radiation incidents. Inspectors saw this information electronically and in easily accessible folders within the department. The radiographers we spoke to knew where to find the information and how to report an incident. All incidents were discussed at the radiation protection committee, which met once a year.
- The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available on a shared drive. This ensured only the most recent versions were available for staff to reference. All diagnostic imaging staff we spoke with were aware of how to access the information. The information was also available in quick reference guides within the department, in control rooms and on mobile imaging equipment.

Duty of Candour

- All staff demonstrated an understanding of Duty of Candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires the hospital to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm that falls into defined thresholds. Care UK had a duty of candour policy and staff in outpatients

and diagnostic imaging could explain what to do if something went wrong. One nurse told us duty of candour was about "being open and honest and able to apologise to patients if things go wrong".

Cleanliness, infection control and hygiene

- Systems were in place to monitor and prevent the spread of infection within the outpatient and diagnostic imaging department. There were no instances of methicillin resistant Staphylococcus aureus (MRSA), Clostridium difficile (C diff) or Escherichia coli (E-Coli) affecting patients in the last year (April 2015 to March 2016).
- The hospital's Patient Led Assessments of the Care Environment (PLACE) audit results for the period February 2015 to June 2015 identified food (including food on wards) was worse than the England average. The hospital scored better than the England average for cleanliness, condition appearance and maintenance, dementia, organisational food, and privacy dignity and wellbeing.
- All areas we visited within the department were visibly clean. Infection control link nurses were appointed for both the outpatients and diagnostic imaging departments, who attended the monthly hospital infection control meetings, and were responsible for maintaining infection control standards and undertaking audits. Link nurses received training on infection control from Care UK.
- When speaking to staff and patients many people commented on the cleanliness of the hospital. A large number of the 71 comment cards completed by patients remarked on the cleanliness which included:
- 'Exceptional service…superbly clean…five star experience'
- 'Environment always looks and smells clean and fresh'
- 'Hygiene was a top priority'
- Gel soap and towels were available and the couches were clean and fit for purpose, with towels available. We observed all clinical staff, including consultants, nursing staff and radiographers washing their hands and using antibacterial gel before and after patient contact, and they were bare below the elbow in line with infection control guidelines. Staff could explain the importance of good hand hygiene. We saw results of a hand hygiene audit which showed 100% of staff observed were compliant with Care UK's policy based on the World Health Organisation (WHO) hand hygiene self-assessment framework.
- Patients were asked to wash their hands and use alcohol gel when arriving at the unit and this was freely available and clearly visible. Hand basins in public areas had clear handwashing signs.
- The design of the department was suitable. Waiting area furniture was clean and in good condition, fully wipeable and compliant with the 'Health Building Note (HBN) 00-09: Infection control in the built environment'. We observed nurses and consultants used clinical wipes on the couch and equipment between patient appointments.
- However, two consulting rooms were found to be non-compliant with paragraph 2.9 of 'HBN 00-10 Part A: Flooring', as the floor coverings were not coved to prevent the accumulation of dust and dirt. Guidelines suggest that a documented local risk assessment is carried out with infection prevention control involvement and a clearly defined pre-planned preventative maintenance and cleaning programme is put in place. Risk assessments were not in place for this risk of infection.
- We saw signed and dated departmental cleaning schedules in outpatients and diagnostic imaging. There was a daily cleaning schedule for all equipment (which also covered weekends) and a monthly deep cleaning schedule. The cleaning schedule included the frequency and staff group responsible for each task, including equipment, furniture, and fittings. A cleaning audit undertaken by the head of nursing in June 2016 found 100% compliance for nursing and facilities in both outpatients and diagnostic imaging.
- Care UK and the hospital's head of infection control audited the diagnostic imaging department in April 2016. Minor issues relating to availability of gloves and aprons were noted and rectified. Spill kits were provided to the department, which can be used to clean up blood and other bodily fluids on any surface and are non-hazardous. We saw evidence of a monthly diagnostic imaging department infection control audit. Results showed the department was routinely 100% compliant. One month saw a drop to 83% due to a patient transfer board being found on the floor, which has now been wall mounted.

Outstanding ☆

Outpatients and diagnostic imaging

Environment and equipment

- Facilities and premises within outpatients were designed in a way that kept people safe. The departments were clearly signposted. The layout of the premises was suitable and fire exits were clearly marked with no obstructions. Fire extinguishers and fire blankets were in date of their annual checks.
- The soft furnishings in the consulting rooms and treatment room were fully compliant, dust free and uncluttered.
- The diagnostic imaging department maintained equipment according to the manufacturer's instructions and tested for electrical safety. X-ray equipment had regular servicing carried out by manufacturer engineers. We saw evidence of the manufacturers' completed service reports. We also saw evidence of routine surveys of all X-ray equipment.
- Within diagnostic imaging a quality assurance programme was in place. We saw evidence that this was regularly carried out and that additional staff were being trained to undertake radiographer quality assurance.
- There was a resuscitation trolley in the outpatients department, which was easily accessible to the radiology department. Emergency drugs were available which were sealed with tamper evident tags. There was a rota for checking the resuscitation trolley. However, we found the checklist was not being completed consistently. A new system of recording was introduced in June, the month prior to our inspection, and there were elements of the new checklist that were not clear and the forms were contradictory.
- There is no capital rolling replacement programme, with individual bids for new equipment being placed when required. All of the imaging equipment was 10 years old but close links with the Radiation Protection Advisor and manufacturers ensured X-ray equipment was not at end of life status. The equipment had regular servicing, quality assurance and dose audit. We saw evidence of a detailed equipment-training programme for radiographers. The lead radiographer signed off each radiographer once considered competent to use a piece of equipment.
- A revised post-operative imaging protocol was established following a risk assessment which addressed concerns about day one post-operative imaging where radiographers may have been required to lift and move patients single-handedly.
- The waiting area was well equipped with chairs and the reception desk was clearly visible on entry. Toilets for disabled people were available, which were clean and fully compliant with an emergency call bell.
- We saw good waste management streaming with domestic bins placed next to sinks, and all sharps bins were correctly assembled, dated and labelled. The sharps bins had temporary closure devices to avoid injury and prevent accidental spillage if the bin was knocked over. We also saw good practice in regards to adherence to the European Safer Sharps guidance as all needles had sheaths.

Medicines

- Emergency medicines and equipment were available and there were systems in place to make sure these were within their expiry date. Arrangements had also been made to have a supply of emergency medicines and equipment available in the reception area to support staff in the event of an emergency in the car park area whilst awaiting external assistance.
- We looked at the safe and secure medicines storage audit, medicines management audit, incidents and complaints and storage security. Medicines, including those requiring cool storage, were stored safely and kept within the recommended temperature range. A limited range of antibiotics was kept in locked cupboards in the treatment room, and no controlled drugs.
- Staff had access to the hospital's medicines management policy, which defined the responsibilities and procedures to be followed for the management of medicines including the obtaining, recording, handling and storage of medicines.
- During our inspection, we found all medicines and prescription pads stored securely. A nurse completed the medicines reconciliation. However, in one consulting room we found two ampules of lidocaine which expired in September 2015, and one bag of normal saline which expired in January 2016. We informed the outpatient manager who disposed and replaced them immediately.
- Fridge temperatures were monitored and recorded, and we found medicines were in the correct temperature range as per their medicines policy. All cupboards in the clean utility containing medicines were kept locked as was the medicines trolley. The clean utility room was locked with a digital lock.

- Patients' medicines reconciliation - identifying and maintaining an accurate list of a patient's current medications - and their allergies were recorded with alert stickers attached to the patient file as part of the pre-assessment check carried out in the outpatient department prior to admission. There were clear systems in place to establish all current medicines taken by a patient and then provide advice around these medicines before a procedure takes place. This included providing leaflets and information during a reminder telephone call just prior to the admission.
- Staff told us that they were confident to discuss any issues regarding medications with the consultant surgeons, anaesthetists or pharmacist.

Records

- Standard operating procedures outlined the processes that were followed for the creation, storage, accessing, and archiving of patient records. The policy also included the procedure for patient records taken to the outreach clinic at Totnes Hospital.
- Patients were referred by GPs or acute trusts using the e-referral system. There was a minimum data set required (patient demographics, NHS number, past medical history and reason for referral) before the patient could be accepted by the hospital and if any data was missing administrators contacted the GP and requested the information. Once the patient had been clinically triaged and accepted a Care UK medical record was created. The notes were available in clinic on the day of the patient's appointment. We were told about one occasion when a patient record was misplaced, a new file was created and provided to the outpatient department in time for the patients appointment.
- Following a pre-assessment appointment an anaesthetist may have required further information, which was requested from the referrer. The patient was then rebooked to see the anaesthetist when the further information had been received.
- Communication to GPs was evident. Following an outpatient clinic appointment a letter was sent to the GP to summarise the patient's condition and to inform of the plan going forward (surgery or no surgery).
- The hospital used an automated appointment reminder system to deliver messages to patients. Messages were sent without patient identifiable information.
- We saw good processes to ensure that patient records were updated quickly. The patient administration system recorded observations completed during the pre-operative assessment, including the weight and height of the patient.
- Consultants never took medical records off site. Medical records were held on the patient administration systems which could be accessed by consultants with password protection. Passwords were changed every 30 days. Data protection principles were followed as outlined in the Care UK policy and individual login details were not shared between individuals. The nursing staff confirmed there had never been an incident when the patient records were not available for the pre-assessment appointments.
- To ensure every patient record contained the correct information filed ready for the patient attendance in outpatients medical records were audited regularly and results from January to March 2016 showed that all records contained the correct information for the patient pathway. This included medication and prescription records, referral letters and consent forms. The link nurse for audit in the physiotherapy department told us they felt confident to check the quality of patient records and they were 'empowered to point out poor practice'.
- We looked at five patient medical notes during clinics, and reviewed a further five archived medical records. They were legible, clear and factual, and gave a clear plan for ongoing medical review. Notes were signed and dated by all staff involved in the patients' care including medical and nursing staff, and physiotherapists. We confirmed that all risk assessments (VTE, falls, manual handling) and nursing assessments were completed at the pre-operative assessment clinic. Anaesthetic and physiotherapy assessments were completed. The patients were confirmed as fit for surgery.
- The hospital used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected. PACS, a nationally recognised system used to report and store patient images, was available and used across the hospital. Diagnostic imaging staff told us that the RIS and PACS systems interfaced well with one another and there was rapid access to stored data.

Outpatients and diagnostic imaging

- Systems were in place to ensure medical records were available for clinics. Staff told us that there were times when the patient administration system would 'go down'. There was a paper back up for these times.

Safeguarding

- There were policies, systems and processes for safeguarding and protecting vulnerable people. The safeguarding policy described the roles and responsibilities of staff in reporting concerns about patients; including deprivation of liberties safeguards (DoLS), Mental Capacity Act 2005 (MCA), safeguarding adults and children, and domestic abuse. All outpatient staff had undertaken a minimum of level two safeguarding training, and diagnostic imaging staff had all undertaken level three safeguarding training for both children and adults. Nursing staff in outpatients told us they would immediately escalate any suspected safeguarding concerns to their manager and alert the hospital's safeguarding lead. All staff in outpatients and diagnostic imaging had completed PREVENT training which covers the protecting of children from the risk of radicalisation.
- All staff we spoke to were knowledgeable about the safeguarding policy and processes and could clearly explain their role in the recognition and prevention of abuse. They described what actions they would take should they have a safeguarding concern about a patient. MCA and DoLS training were mandatory and all staff were up to date through their e-learning systems.
- We were told about a patient who had arrived for a pre-assessment appointment and was identified by the outpatient resuscitation nurse to be confused. The nurse contacted the hospital safeguarding lead to raise their concerns, and staff acted appropriately in this situation to protect the patient.
- All hospital staff received training on female genital mutilation at a recent clinical governance day. The hospital's safeguarding lead carried out training to raise awareness and inform staff how to escalate any concerns.

Mandatory training

- The hospital provided a programme of mandatory training for staff.
- There was a mixture of learning methods to suit personal learning preferences and staff were encouraged to take control of their own learning. Most training was provided through e-learning or face-to-face.
- We saw records dated April 2016 and overall the hospital compliance with mandatory training was at 98%. Training included; prevent training, basic life support, equality and diversity, fire safety, moving and handling, health and safety, infection control, medicines management, mental capacity act and deprivation of liberty safeguards, safeguarding adults, child protection, safeguarding children, information governance, patient consent, clinical governance, lone working, duty of candour and chaperoning. Compliance was at 100% for the outpatients, diagnostic imaging and physiotherapy department with the exception of the following: 80% for outpatients in moving and handling; 50% in physiotherapy for moving and handling; and 60% for outpatients and 50% in radiology for information governance. However, it should be noted that this relates to low numbers of staff. Staff training analysis reports were produced every month and discussed at the heads of department monthly meetings. By the date of inspection, all staff had completed their mandatory training.
- The hospital had no clinical activity for one day a month to allow for a multidisciplinary team quality governance meeting, team meetings and staff training events. Staff at all levels told us that these days were very useful, to have a dedicated day for team meetings and training.
- We saw evidence of a detailed equipment-training programme for radiographers. The lead radiographer signed off each radiographer once considered competent to use a piece of equipment. Ongoing competencies were assessed annually.

Assessing and responding to patient risk

- Patient risk assessments were completed and evaluated. Every patient had an individual risk assessment carried out at pre-assessment to ensure they were physically fit to have an anaesthetic and surgery. The assessment was undertaken by the consultant surgeon and anaesthetist, and included a full review of the patient's medical history and current factors that increased patient risk such as venous thromboembolism (a condition where a blood clot forms in a vein) and a water low score (which gives an estimated risk for the development of a pressure ulcer).

The risk assessment also included a falls assessment and the malnutrition universal screening tool (MUST) to identify adults who were malnourished or at risk of malnutrition. VTE assessments had been completed; allergies recorded, and alert stickers were available for those patients where this would have been applicable. All patients were given a leaflet on VTE and we saw this explained to patients in simple terms.

- There were clear pathways and processes for the assessment and management of deteriorating patients within outpatients or diagnostic imaging who were clinically unwell and required hospital admission.
- There was a local cardiopulmonary resuscitation procedure. This outlined the resuscitation team which included a consultant anaesthetist, resident medical officer, resuscitation officer, theatre appointed person, shift leader on the ward and ward manager or deputy. The resuscitation team held a resuscitation bleep which was tested daily. On both days of our inspection we observed this test being completed. The resident medical officers were trained in advanced life support. The hospital held cardiac arrest scenarios twice a month and these were attended by members of the multidisciplinary team. The emergency scenario audit tool kit assessed compliance with these scenarios and identified lessons learned and points for improvement.
- As part of the referral criteria the hospital did not accept patients with a body mass index (BMI) over 42 for general surgery or more than 45 for local anaesthesia. One nurse informed us a patient had arrived for their pre-assessment appointment who exceeded the agreed criteria, and they had to inform the patient their BMI was too high. This was done kindly with the consultant and the patient was supported with a weight loss plan.
- The radiation protection service at a neighbouring NHS trust led the radiation protection service at Peninsula NHS Treatment Centre. They provided the radiation protection advisor and medical physics expert for diagnostic imaging. The service level agreement had not been reviewed since 2012 but there were no perceived risks. At the time of the inspection, the radiation protection advisor informed us the medical physics service was scheduled for review.
- There were clear signs and information in the diagnostic imaging department informing people about areas and rooms where radiation exposure took place.
- The imaging department ensured women who used the service who were, or may be pregnant, always informed a member of staff before they were exposed to any radiation. There was a radiation protection supervisor for the hospital with an additional radiographer undergoing training. Their roles met the Ionising Radiation Regulations.
- We saw evidence that radiographers, with advice from the radiation protection advisor, carried out risk assessments for all new equipment or procedures, including in line with IRR99 for new equipment and new imaging techniques. The diagnostic imaging department adheres to a corporate policy for the escalation around urgent and unexpected findings.

Nursing staffing

- There were adequate nursing staff levels to safely meet the needs of patients. The team consisted of 1.0 whole time equivalent (WTE) nurse manager, 4.6 WTE registered nurses and 2.0 healthcare assistants. In addition for the ophthalmology clinics there were 1.8 WTE ophthalmic nurses plus one agency nurse. There were three WTE physiotherapists. There was no use of bank or agency nurses from April 2015 to March 2016, but at the time of our inspection there was one bank nurse in outpatients and one in ophthalmology.
- An outpatient staffing tool had been developed to meet patient acuity and dependency. This model was based on the staffing required by scheduled outpatient clinic as well as outpatient activities and treatments. Staff allocations were planned on a monthly period.
- There had been no vacancies in the outpatients department from April 2015 to March 2016. However, two nurses had left the department respectively in April and May. Overall sickness levels were also below average when compared to the other independent healthcare providers who have provided data to the CQC over the same reporting period.

Medical staffing

- The hospital was entirely consultant led which meant most patients met the consultant who would be performing their procedure. The hospital employed four orthopaedic consultants and four consultant anaesthetists. Other consultants worked on the hospital's bank.
- Radiology cover was sufficient in the diagnostic imaging department. There were four WTE radiographers in diagnostic imaging. There were no vacancies and no use of agency staff at the time of the inspection. There were

two radiologists who were based off site who provided cover for the hospital. The radiologists told us they had excellent working relationships with the consultant surgeons.
- Planned staffing levels for each clinic were determined based on the activity in the clinic.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. Senior staff were aware of the hospital's major incident policy and how to access this.
- There were effective arrangements in place in case of a radiation or radioactive incident occurring and diagnostic imaging staff were aware or the procedure and their roles and responsibilities in the process.
- Staff reported fire alarms were tested weekly and staff were aware of where and how to evacuate patients. Annual fire drills with staff were completed. Fire marshals were appointed.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of the outpatients and diagnostic imaging department was not rated due to insufficient data being available to rate these departments nationally.

We found:

- The use of best practice was evident throughout the outpatients and diagnostic imaging department.
- The hospital used national surveys to capture patient outcomes.
- Multidisciplinary team working was evident throughout the department.
- Diagnostic imaging and physiotherapy was available to inpatients seven days per week.
- All outpatient and diagnostic imaging staff had received an appraisal by April 2016.
- Staff demonstrated an understanding of consent and decision making requirements of legislation and guidance.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and Medicines and Healthcare products Regulatory Agency (MHRA). Policies were available to all staff via the intranet system. There was a system in place for reviewing and disseminating alerts and guidance that are suitable to the care delivery within the centre. The clinical governance manager circulated alerts and guidance to relevant managers, and confirmed this information was received and actioned. We were shown a spreadsheet with update national guidance and confirmation that they had been sent, received, and actioned by managers. Staff told us that they knew how to access these documents and had opportunities to access computers to view these. Alerts and guidance are a standing agenda item for discussion at monthly Quality Governance meetings.
- The diagnostic imaging department used diagnostic reference levels (DRLs) as a guide to optimisation of medical exposures to keep patients safe. These levels were used to help staff make sure the right amount of radiation was used to image each part of the body. Local DRLs had been established for some examinations and were reviewed by the medical physics service in 2015. Exposure charts were available in the X-ray rooms visited and exposure parameters were pre-programmed on the equipment.
- The provider had a radiation safety policy. The head of radiology signed off all new documentation and revised procedures but it was not entirely clear what the corporate ratification procedure was for policies and procedures. Clinical staff had a sound knowledge of Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) relevant to their area.
- Referrers and radiographers could access a referral system electronically. This was a radiological investigation guidelines tool from The Royal College of Radiologists which helped radiographers determine the most suitable imaging investigation or intervention for a given diagnostic or imaging problem.
- Diagnostic imaging management told us they benchmarked their service against other hospitals within the provider group and staff were able to rotate to other sites to gain knowledge and experience. The corporate provider employed an external radiology consultant as an advisor to implement an audit of radiology reports including discrepancies.

Outpatients and diagnostic imaging

- A radiology request card audit was carried out monthly to ascertain compliance with Care UK's procedures and referral criteria. The audit identified minor non-conformities with incomplete forms. Image quality audits were performed six monthly at corporate level and, due to the small size of the department, the lead radiographer was able to continuously monitor the quality of the images produced. Reject analysis of sub-standard images was good with audit results at less than 4% rejected.

Pain relief

- In the physiotherapy department, staff encouraged patients to talk to their GPs about pain relief. If a patient reported worsening pain they would immediately escalate to the resident medical officer (RMO) if medication was required.
- Staff were rarely required to administer pain relief due to the nature of the clinics. However, nurses asked patients about pain during appointments, and this was recorded electronically.
- Physiotherapists told us that there was an escalation process they followed if a patient reported worsening symptoms. They would request that the RMO assess the patient and prescribe medication if required.

Nutrition and hydration

- A patient's nutritional needs were discussed as part of their pre-assessment. Any dietary requirements were added to the patient administration system. Staff told us that halal meals were being increasingly requested, and that this had been added to the list of available options for patients. Information on dietary requirements would be flagged to ward staff in advance of admission.
- During our inspection we saw water fountains available for patients to use in the outpatients department next to the diagnostic imaging department. Tea and coffee were available in the hospital café just outside the department. Staff demonstrated a good understanding of the importance of assessing nutrition and hydration needs of patients.
- Food and drink for were available for patients who were in the department for any length of time. Patients were advised to allow up to three hours for their pre-assessment appointment. We saw patients offered complimentary tea and coffee vouchers if their appointment had been delayed.

Patient outcomes

- GPs, local trusts and CCGs informed the hospital of any complications or concerns regarding their patients so that action could be taken.
- The physiotherapy team contacted all hip replacement patients by telephone two weeks post-operatively to review a patient's progress. Those patients identified as not reaching their mobility goals were invited back for review by the physiotherapy team. A six-week follow up appointment was carried out by the consultant surgeon.
- The physiotherapists had a yearly follow up clinic for all patients who had a total knee or hip replacement outcome data. This included an x-ray which was checked by the consultant, Oxford hip and knee scores (simple scoring system which provides an overall scale for assessing outcome of hip and knee interventions). However, patients were encouraged to contact the physiotherapy department if they had any concerns before their yearly follow up appointment.

Competent staff

- Systems were in place to ensure all staff had the specialist knowledge and skills to deliver effective care to patients with their presenting conditions.
- Staff learning and development was identified through the appraisal process and through informal discussions. Staff told us they had been well supported with their training needs.
- All staff we spoke to told us they had received an appraisal in the last year. The data supplied by the hospital showed 100% of outpatient and diagnostic imaging staff had received an appraisal by April 2016. Annual appraisals were carried out by heads of department and managers. Staff we spoke to were positive about the quality of supervision they received. All outpatient nurses, healthcare assistants and diagnostic imaging staff had received staff appraisals for the last two years.
- There was a strong commitment to training, development and education within the department. Staff said that they felt well supported in their continuous professional development, and were provided with opportunities to attend external training. For example, a physiotherapist told us the team were able to take time off to have training on shoulder manipulation and were encouraged to cascade the training to their colleagues. The outpatient manager

confirmed the hospital invested in staff and training, and finance and resources were made available. She was able to approve courses on patient safety, human factors, electrocardiogram courses, national vocational qualifications level 3 and an ophthalmology course. Managers were sent on a 'management essentials' course.

- Induction policies were available for new staff and temporary/agency/locum staff. These both covered the responsibility of the manager and the member of staff. For temporary/agency and locum staff this also included a checklist which covered, proof or registration; training (safeguarding Children Level 3 and Vulnerable Adults level 1); evidence of mental capacity act training; completed DBS form; proof of identification; references, evidence of hepatitis B immunity; and evidence of IR(ME)R training for diagnostic imaging staff.
- We spoke to an agency nurse in outpatients who confirmed that all training was carried out with their agency, and was up-to-date. The outpatient manager and agency nurse both told us that the induction process was the same as that for permanent staff, and included: IT access and explanations of systems used; explanation and training of equipment to be used in the role; infection prevention and control; a safeguarding overview; and a session with the health and safety nurse. The nurse was supernumerary to the staffing requirements for one and a half weeks so they were able to shadow other nurses.
- An induction checklist for all new staff covered orientation; IT access and training; process of reporting accidents and incidents; explanation and training of any equipment to be used in the role; medicines management; and familiarisation with local patient pathways and standard operating procedures.
- The hospital had no clinical activity for one day a month to allow for a multidisciplinary team quality governance meeting, team meetings and staff training events. Staff spoke to us positively about having a dedicated day per month for learning.
- We saw evidence of role development radiographers. Continual professional development (CPD) within imaging was encouraged. During the monthly governance day radiographers were able to undertake mandatory training, CPD and any additional learning that they require.

Multidisciplinary working

- Patients attend a one-stop clinic and were advised in advance that this will take up to three hours. Patients were seen by nurses, consultant surgeons, consultant anaesthetists, diagnostic imaging staff and physiotherapists as required during this time.
- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patient care and treatment. We saw consultants, nurses, healthcare assistants, radiographers and cleaning staff working professionally together and co-operatively within outpatients and diagnostic imaging. This ensured care was co-ordinated to meet the needs of patients. Staff reported good multidisciplinary team working with meetings to discuss patient care and treatment.
- We were told that the radiology lead had regular meetings with hospital referrers to discuss service requirements and issues that had arisen as well as developing new imaging techniques. Radiographers told us there was always a radiologist available for advice relating to imaging requests and unusual or urgent findings, and there was a good link with the local NHS trust radiology department.
- One physiotherapist was dedicated to the pre-operative assessments, working closely with the outpatient team.

Seven-day services

- The outpatient department operated a five-day outpatient service from Monday to Friday, from 8am to 4.30pm.
- The ophthalmic clinic operated from Monday to Friday from 8am to 4 pm. Cataract surgery was outsourced (obtaining services by contract from an outside supplier) to another company, but the hospital received the referral and the initial triage and pre-assessment appointment was provided by the Peninsula NHS Treatment Centre.
- The diagnostic imaging department provided emergency cover 24 hours per day, seven days per week and the radiographers work one weekend in four on-call. Radiology staff were employed on a flexible working contract in order to ensure all clinics and theatres were covered and staff were able to flex with hospital demands. Radiographers worked as standard on a Saturday morning to cover post-operative plain film imaging.

- Physiotherapists provided on-call support.

Access to information

- Information to deliver effective care was readily available. Staff said they were always able to access information they required for patients. Between January and March 2016 the hospital said there were no patients seen as outpatients without all their relevant medical records available.
- The hospital used an electronic patient record system and archived hard copy patient files on site. Two people could access the electronic patient record at any one time. Consultants were able to access the electronic patient records via password protection on external computers through a virtual private network. Staff said the electronic patient record was easy to access and use.
- There was a range of documentation and this was easily accessible. There were a variety of patient information leaflets available, and access to a translation service was advertised within the department.
- Staff accessed radiology images through the PACS (picture archiving and communication system) and for images acquired off-site, the image exchange portal and other local image gateways were utilised. All staff knew how to access images and informed us there was good and quick access to results. Image requests were predominantly electronic via the hospital information system. Radiologists who were based off-site had instant access to images.
- Patients were given a letter with a summary of their condition and to inform them of the plan for surgery as they left the outpatient department. A copy of the letter was sent to the GP and confirmation of whether the patient could have surgery at the hospital (having met the referral criteria).
- Consultants told us only three members of staff within the hospital were able to access micro/haematology results, due to the complexity of the training provided by the local acute trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke to demonstrated an understanding of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). All staff had attended mandatory training; they knew what their responsibilities were and how to apply them within everyday practice. In both the outpatient and diagnostic imaging departments extra time would be allowed if staff were made aware that a patient had learning difficulties and may require extra time.
- The physiotherapists told us they had a patient with learning disabilities and had both knees replaced. The patient would come to the physiotherapy department for their appointment and would be allotted extra time to support their needs.
- Consent was obtained from patients prior to commencing care or treatment, we saw evidence of this during observation of pre-operative assessments and in the 10 archived medical records we reviewed. Consent was complete and signed by both the consultant and the patient. The patients also consented to their personal data being recoded on the national joint registry, this allowed a national database to be maintained to help identify patients who have received specific implants that are performing poorly, link patients primary and revision procedures and invite patients to provide feedback. Throughout the inspection we saw staff explaining the assessment and consent processes to patients.
- Staff showed a consistent understanding of the rights of people subject to the Mental Health Act and had regard to the MHA Code of practice, and this forms part of the mandatory training e-learning package. Patients with mental health issues were triaged within the department and were be treated if their needs could be met.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

Overall, we have rated caring of the surgery service as outstanding because:

- Care from the nursing, medical and support staff was provided with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.
- Feedback from patients was overwhelmingly positive about staff and the service they received, both in the patient interviews and on comment cards received.

- There was an embedded patient centred culture, and staff demonstrated genuine compassion for patients and their families. Staff took time to engage with patients and families to understand their specific cultural needs.
- Staff provided emotional support to patients, identifying anxieties and responding to ensure the patient was at ease.

Compassionate care

- People who use services are active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff always empowered people who use the service to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to deliver care. Physiotherapists provided patients with walking aids and encouraged independent movement and mobility within a safe environment. The physiotherapy team worked with patients to build their confidence and optimise progress. People's individual preferences and needs are always reflected in how care is delivered. We saw all staff going the extra mile to support patients' personal needs. For example, one patient who had a knee arthroscopy told staff they were very active and keen to walk trails. The physiotherapy team decided to see the patient once a week for six weeks in the outpatient clinic for high end balance and functional work to help the patient achieve their goal of walking the trails.
- The outpatients' team took time to engage with patients and their families in order to identify their specific cultural needs We were given an example of how all staff were able to respond to a patient's religious and cultural needs to provide care the patient and their family were comfortable with.
- Throughout our inspection we observed patients being treated with the highest levels of dignity and respect. Staff took time to interact with people who used the service and those close to them in a respectful and considerate manner. We observed interactions between staff and patients and their relatives. Staff were open, friendly and approachable but always remained professional.
- During our inspection we saw excellent interactions between staff, patients and their relatives. We observed these interactions to be very caring, respectful and compassionate. For example, when a patient became concerned about the length of time they had been waiting for an appointment the outpatients department manager took them to their office to explain what was happening and offered vouchers for tea and coffee.
- Feedback from people who used the service and those who are close to them were continually positive about the way staff treated people. People reported that staff go the extra mile and the care they received exceeded their expectations. Patients provided consistent positive feedback in the 71 comment cards received by patients. Comments relevant to compassionate care included:
  - 'Felt I wasn't treated as a case but as an individual'
  - '5 star treatment from day one to discharge'
  - 'From the moment I came in I was treated lovely by staff…5 star'
  - 'Could not ask for better treatment'
  - 'I actually enjoy coming here, everyone is so lovely and friendly and caring'
  - 'The receptionist was great…had to call after I got lost and she helped me'
  - 'A completely pleasurable experience'
  - 'Very helpful staff, especially with fussy baby, clean baby changing facilities'
  - 'Lots of friendly smiles and chatter…glad I was advised to bring a book'
  - '5 star treatment from day one to discharge'
- Twenty five patients reported feedback to their local healthwatch regarding care at the hospital. Twenty three of these comments were highly positive, one was mixed and one was negative. One patient said " there was huge consideration to fit in with me rather than the other way around…rather than talking around me they were talking to me"
- The radiographers we observed demonstrated compassion and care when speaking with patients. There was an obvious patient focused approach throughout the department. Privacy and dignity were maintained and all patients were identified and spoken to within the x-ray rooms away from public environments.
- The hospital participated in the NHS Friends and Family Test, which asks each patient how likely they were to recommend the hospital to family and friends. The results for May 2016 were displayed in the outpatients waiting area which showed 97% of patients who responded would recommend the treatment centre, this was at 99% in April 2016. This information was completed by patients on one of two feedback tablets at

reception that all patients were encouraged to use. One tablet was used to record pre-operative feedback, the other for post-operative feedback. In addition to this there were paper questionnaire for specific patient specialities, for example, the ophthalmic questionnaires in larger type.

- Outpatient and diagnostic imaging staff told us they would always stay after their hours if patients and the hospital required it.
- The chaperone policy set out guidance for the use of chaperones and procedures that should be in place for clinical consultations, clinical examinations, investigations and clinical interventions, particularly in relation to intimate procedures. Patients were advised that chaperones were available to support them at any time during their appointment. Staff also confirmed they would be available to chaperone patients if required.
- The hospital was not near a local bus route. We were told about a patient who did not have access to a car and had contacted the outpatients department to complain about the difficulties they would have in getting to the hospital. The manager arranged for a taxi for the patient to get them to and from the hospital free of charge.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. We observed staff explaining things to patients in a way they could understand. We observed patient assessments and saw good and concise explanations given to patients regarding what to expect before, during, and after surgery, and allowed plenty of time for patients to ask questions. Patients were also given copies of their consent form which was signed by the consultant.
- We observed staff taking time to talk to patients. They involved and encouraged both patients and their relatives as partners in their own care. Patients we met spoke highly of the service they received. All the feedback we received from patients was very positive about their care. Feedback included:
  - 'feeling like part of a family'
  - 'part of the team'
  - 'feels like private healthcare on the NHS'
  - 'staff couldn't do enough for me'
  - 'the service was absolutely fantastic, I couldn't fault it'
  - 'I was so glad to have an opportunity to speak to the anaesthetist'
  - 'for my first appointment I arrived at 8.30am and was home by 11am… all tests done'
- Four patients told us they had undergone a previous procedure at the hospital and would not consider going elsewhere for treatment; including one who asked to be treated by the same consultant again.
- Members of the patient forum acted as patient ambassadors who were available to speak to new patients who might be anxious regarding a future stay at the hospital.
- We observed all healthcare professionals introduce themselves to patients and explain their roles and responsibilities.
- Staff recognised when patients required additional support to help them understand and be involved with their treatment. For example, ophthalmology patients often required extra help with eye drops, and staff ensured that patients understood what they needed to do before they left the department.

Emotional support

- Staff understood and demonstrated an understanding of the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We observed staff providing emotional support to patients and relatives during their visit. We saw anxious patients being allowed extra time to resolve and relieve their individual concerns, and staff were reassuring and knowledgeable.
- Patients and their relatives were spoken to in an unhurried manner and staff checked if information was clear and understood. We saw staff tell patients to call the department if they had any questions when they got home and were provided with a direct number to the department. Patients could also come in for another appointment with outpatient staff or their anaesthetists if they had any particular concerns.
- The pre-operative nursing assessment included a check for the patient's emotional wellbeing. The patient was asked if they suffered from depression, anxiety state, mental illness or take medication for these. If yes, nurses

noted the patient's emotional state (for example, calm & co-operative, anxious-agitated) and cognitive state. Staff in all departments were notified through an alert on the patient's electronic record.

- Patients were given detailed advice on what to do at home prior to the day of their surgery. This included using an antimicrobial preparation for three days prior to the operation to reduce the risk of post-operative infection. They were also advised of what to eat and drink, and what to bring in to hospital. Staff went through what would happen to them on the day of the surgery, and what they could expect to be able to do following their surgery. Staff reassured patients they would not be discharged until they were medically fit enough to go home. For patients with higher anxiety, staff offered them an opportunity to look at the ward before they went home so patients could be reassured.

Are outpatients and diagnostic imaging services responsive?

Good

Overall, we have rated the responsiveness of the outpatient and diagnostic service as good because:

- The hospital was meeting its referral targets and most patients were seen within six weeks of their referral.
- Patients could access care and treatment with a choice of appointments being offered to suit them.
- Care and treatment was only cancelled or delayed when necessary.
- Support for patients with learning difficulties was always available.
- There had been no formal complaints regarding outpatients or diagnostic imaging in the last from April 2016 to March 2016.

However:

- Signage to the ophthalmic clinic was the same size as other signage around the hospital and would therefore not meet the needs of patients with impaired vision.

Service planning and delivery to meet the needs of local people

- The hospital had planned its activities around the needs of the local population. They accepted referrals from the NHS through the choose and book system. Patients were offered a choice of outpatient appointments via the referral management centre. Activity in outpatients was planned and reviewed at weekly scheduling meetings. Outpatient clinics had previously been held on a Saturday to accommodate patient choice and increased activity.
- The outpatient and diagnostic imaging departments were clearly sign posted to help patients locate the departments, the reception team were available for further guidance.
- The waiting area design enabled the comfort of patients while waiting for their appointment. Sufficient seating was available and patients had access to water, a television, internet connection and magazines.
- Parking was available for patients free of charge with disabled places and a drop off area at the main entrance. Additional car parking space was available nearby. Patients told us they had not had any problems parking at the hospital.
- We were given an example of how all staff were able to respond to a patient's religious and cultural needs to provide care for the patient. Staff adapted protocols regarding staffing arrangements and meals provided to ensure the patients' needs were met.
- Radiology had extended working hours, to include Saturdays to meet the demand for imaging services for post-operative patients.
- There were protocols in place for managing patients with challenging behaviour in the outpatient or diagnostic department, and staff were aware of these protocols. For example, there was a pathway for staff to follow on the patient administration system for patients with dementia. The patient would be flagged on the system which would then be escalated to the ward manager, the scheduler and anaesthetist to ensure that the patient's needs would be met. A carer was able to stay overnight with patients with challenging behaviours.
- The diagnostic imaging department offered an 'express' MRI service from 2015. When patients attended the clinic for their appointment radiology received the request for imaging and completed all booking information (through the third party provider), they undertook all safety checks, coordinated all patient information and care and booked the follow up clinic appointment for the patient to return once the images had been reported.

Outstanding ☆

Outpatients and diagnostic imaging

Access and flow

- We found that patients experienced a seamless flow throughout their patient journey with many patients not identifying a difference between their preassessment, surgery, and postoperative care.
- The hospital delivered an 18-week referral to treatment pathway. Patient choice was demonstrated by being able to choose dates of outpatient appointments. A comprehensive one stop consultant-led outpatient service was in place where patients were seen by the consultant surgeon, have a nurse pre-operative assessment, diagnostics (including radiology, phlebotomy and physiotherapy) and leave the facility with a surgery date with the average total journey time of three hours.
- Patients could access care and treatment with a choice of appointments at a time to suit them. Patients were referred by their GP through a referral support service who used clinicians to triage and align referrals to the correct place. The hospital then undertook its own triage and confirmed or rejected the patient. Hospital administration staff contacted the patient to arrange the pre-assessment appointment. There was a maximum six weeks waiting time for most outpatient appointments, with the majority of patients seen within two weeks.
- 48 hours prior to their appointment a reminder text message was sent to patients. If a patient did not attend (DNA) staff would call them to check that they were okay and rebook their appointment. If they could not be contacted during the day then reception staff would call patients in the evening. Patients would be offered a new appointment within the following five days. If a patient does not attend two outpatient appointments the hospital would refer the patient back to their GP.
- DNA rates were low. From January to June 2016 monthly outpatient appointment DNAs ranged from 2.0% to 3.4%. For diagnostic imaging the range was 0.0% to 4.2%.
- Once patients arrived in the department, most were seen promptly and if clinics were running late we observed staff inform patients of the reason for the delay and how long the delay was likely to be. On day two of the inspection a consultant was off sick which had an impact on the waiting times for some patients. We saw other consultants were willing to step in and add the patients to their own lists, and the outpatient manager rearranged their staff to provide effective support. The department did not have a board to display waiting times for appointments. A sticky note was added to the patients' notes recording the time the patient arrived and the time of their appointment. This allowed the receptionist to keep the outpatient manager informed of any patients whose appointment were running behind, as well as a prompt for the nursing and clinical staff.
- We saw patients being taken in to the manager's room to explain why their appointment might be delayed. Patients were informed that there might be a delay for their appointment, and were offered an opportunity to rebook if they would prefer. We saw patients offered free tea and coffee, and asked if they would like to wait in the café area, and assured that they would be called and not miss their appointment.
- Care and treatment was only cancelled or delayed when necessary. There had been four cancelled clinics from January to June 2016, three of which were cancelled following capacity and demand exercises, which reduced backlogs of patients; and one where a consultant was required to take over a theatre list.
- There were no patient waiting breaches within radiology. All plain film imaging was carried out as walk in appointments, all cross sectional and ultrasound imaging was appointed within two weeks of referral. Reports for all imaging modalities were available within three days.

Meeting people's individual needs

- The department offered lots of patient information regarding follow up clinics, surgical procedures, and access to results, informing the radiographer of possible pregnancy as well as information on patient surveys and how to make complaints.
- The physiotherapists told us about a patient who was struggling to attend their follow up appointment so they arranged a taxi to bring the patient in to the hospital. They also used patient transport providers who could offer patients a door-to-door service.
- The physiotherapy team had a regular 'knee group' of up to 16 patients who had their physiotherapy together, allowing them to share experiences during their exercise class. Patients attend this group between two and five times depending on need. If patients did not attend their appointment a physiotherapist would call to check they are okay and to reschedule their appointment.

- Staff allowed extra time for patients with learning difficulties. For example, patients were encouraged to bring their carer with them to their appointments, and extra time was allocated to ensure the patient fully understood their treatment plan before they left the department. For those patients who could not read the staff ensured that the carer was able to support the patient, and encourage both the patient and carer to contact the department or come back in if there was anything that they need to be clarified. Patients were able to come back in and have a second appointment with their consultant or anaesthetist if they require.
- A dementia diagnostic would be completed at the pre-operative assessment if the patient had dementia. Any packages of care would be identified at the pre-operative stage and the day surgery unit or ward informed. Staff also recorded a list of all leaflets given to the patient at the pre-operative assessment.
- Translation services were available through a language line. Leaflets in the waiting area promoted the translation services. Staff could tell us how they would access translation services. An induction loop was available for people who were deaf or hard of hearing. Induction loops help people who are deaf or hard of hearing pick up sounds more clearly, by reducing background noise. There was easy access for disabled users including disabled parking bays near the main hospital entrance, a ramp to the front entrance and a lowered section of the reception desk for wheelchair users.
- We observed one patient pre-assessment appointment where a patient flagged that they were the main carer for their wife. However, the nurse did not pick this up and the opportunity was missed to find out who was going to look after their wife when they had surgery.
- We noted that the signage to the ophthalmic clinic was the same size as other signage around the hospital and would therefore be harder for patients with impaired vision to read.

Learning from complaints and concerns

- There was a Care UK compliments, concerns and complaints policy, covering definitions, roles and responsibilities monitoring and reporting. The hospital director had responsibility of overseeing the management of complaints supported by all members of the senior management team, including the head of nursing, medical director and financial manager. The hospital director was responsible for ensuring qualified staff investigated the issues raised. This included the clinical governance manager and, where indicated, the head of department and any member of the multi-disciplinary team named or involved in the complaint being investigated.
- There had been no formal complaints regarding outpatients or diagnostic imaging from April 2015 to March 2016. As the departments received very few informal complaints it was easy for them to be resolved quickly, recognise any emerging themes and address them immediately. Learning from patient complaints, concerns and feedback was discussed at departmental meetings, and individually with staff where appropriate.
- Patients were actively encouraged to leave comments and feedback via the patient feedback form, which were available in the waiting areas and reception for patients wishing to make formal complaints. We saw posters in the department informing patients how they could give feedback.
- Patients who did raise a concern were treated with compassion, dignity and respect. During the inspection we saw patients complain regarding the waiting time for their appointment, this was as a result of staff sickness. Staff addressed the concerns quickly and took patients to one side in the manager's office where they could discuss their issues.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

Overall, we have rated well-led of the outpatient and diagnostic service as outstanding because:

- We were impressed at how empowered staff felt. All staff were encourages to take ideas forward and were recognised for doing so.
- The leadership, management and governance of the hospital assured the delivery of high-quality person-centred care. There were clear governance arrangements in place which reflected best practice, staff at all levels said information was always cascaded to keep them well informed.
- Staff were aware of the corporate vision and strategy.

Outpatients and diagnostic imaging

- There were clear governance arrangements in place which reflected best practice and were managed proactively. All staff were encouraged to attend the monthly quality governance meetings and were actively engaged in the hospital's governance processes.
- Managers encouraged learning and a culture of openness and transparency.
- Feedback from staff was overwhelmingly positive about department and senior managers. The senior management team were visible, approachable and supportive.
- There was an excellent working culture within the department, which was patient focused and interactions with patients were positive. Staff were encouraged to identify ways to improve the service for patients and were empowered to make changes themselves.

Vision and strategy for this this core service

- Care UK set missions and values for Peninsula NHS Treatment Centre. The values were: to put patients at the heart of everything they do; every member of staff made a difference; and together they make things better. The Care UK mission was 'fulfilling lives', with staff working to achieve this every day. Three key aims underpinned the mission: focus on quality, lead change, and drive innovation. Staff at all grades had a good understanding of the core values of the service and were committed to providing patient-centred care.
- The outpatient philosophy was to provide a safe caring environment that ensured privacy, dignity and confidentiality, and to make patients feel welcome with a smile. We saw all staff welcome all patients and family in this way.
- Clinicians were actively involved in the design and delivery of care pathways. Care UK employed a consultancy team to support management and staff to make efficiencies in utilisation through staff consultations. In order to increase patient throughput in outpatients, the department were asked to trial a new way of working where two patients would arrive in the department at the start of the orthopaedic clinics, one would be taken to the x-ray department, and the other seen by the consultant. However not every patient needed an x-ray, and some patients would be delayed, which led to an increase of informal complaints from patients, and frustration for consultants and outpatient staff. Consultants noted that the first two appointments were 10 minutes apart and that this went against British Orthopaedic Association guidelines. The senior management team consulted with the outpatient staff and asked them for ideas to increase patient throughput. They suggested staggered arrival times for patients and this has been successful.
- Diagnostic imaging staff told us about the plans for expanding the service to include spinal imaging and a third theatre. The departmental lead was working with senior managers at the provision of services and the expansion of staffing levels to accommodate the changes.

Governance, risk management and quality measurement for this core service

- There was a clear and effective governance structure for the department. The structure integrated systems, processes and behaviours in order to achieve the hospitals objectives, safety and quality of services as they related to patients and their carers, the wider community and partner organisations. For example, we saw minutes which showed that learning from never events at other Care UK locations were shared with outpatient staff. Staff were encouraged to work as a team, discuss and share ideas for improvement and change and highlight any near misses in order to improve patient safety: "Respect for one another and the ability to listen to each other are important in order to provide optimal care". Staff understood their roles, and what they were accountable for.
- We saw minutes from the monthly staff meetings where incidents, service provision, training, compliance and risks were discussed. Minutes were available for all staff to access.
- Consultants and managers from across the hospital attended the quality governance assurance meeting every month. We saw in minutes that a range of topics were discussed including: outcome data; alerts and guidance; incidents; mandatory training; health and safety; friends and family scores; patient involvement; duty of candour; consultant reports; risk registers; medicines management; medical devices; infection prevention; audit results and outcomes; resuscitation; policy updates; complaints and plaudits; waiting times; shared learning; and departmental issues. Actions were noted and tracked at following meetings to keep them reviewed and updated. We noted that these meetings were well attended by staff from all departments.

- The heads of department also met once a month. We saw in minutes a range of topics were discussed including: hospital director update; human resources; clinical report; staff health, safety and environment; and departmental reports.
- The outpatients department had monthly meetings that formed part of the monthly Peninsula hospital governance days. We saw minutes of these meetings, which covered training on new equipment, revalidation, continuous professional development, and incidents.
- The radiation protection committee met at corporate level which was attended by the local radiology lead and the radiation protection advisor. The radiation protection advisor produced an annual report for the department around compliancy against the radiation regulations and any areas that were required to be addressed.
- The radiology lead attended a three monthly regional team meeting where all diagnostic leads were involved including the regional audit lead and head of diagnostics.
- Regular auditing took place with evidence of trends and improvements. Performance data and quality management information was collated by Care UK staff and examined to look for trends, identify areas of good practice or question any poor results. The Peninsula hospital was benchmarked against other Care UK hospitals in the south west, and benchmarking reports were produced and shared each month.
- The departments understood, recognised and reported their risks. A hospital wide risk register was in place and we noted this was kept up-to-date. Risks were shown by specialty, allocated a risk level and mitigating actions were in place with review dates. Each department also had a risk register. All ten risks on the outpatient risk register were rated as 'green' (low risk). Both diagnostic imaging and physiotherapy had one amber risk and no red risks. Their amber risks had full mitigating actions in place.

Leadership / culture of service

- The local leadership of the outpatient and diagnostic imaging department had the skills, knowledge and integrity to lead their teams. The clinical managers were an experienced strong team with a commitment to the patients who used the service, to their staff and to each other. They were visible and available to patients and we saw and heard good support for all members of the team. We received consistently positive feedback from staff who had a high respect for their managers. Both the outpatient and diagnostic imaging manager were extremely proud of their staff. They told us their staff were fantastic, hardworking, and flexible and that they offered excellent patient care.
- Managers told us they had the capacity to do their job, and had the necessary skills knowledge and experience. They understood and demonstrated a thorough understanding of the challenges to good quality care and were able to identify the actions to address these challenges.
- Managers encouraged learning and a culture of openness and transparency. We saw awareness that their staff required different leadership styles and were flexible in their approach to the needs of their teams. The radiology manager was working with staff in order for them to develop their managerial skills and offer them additional training and guidance for future leadership. The radiology manager was compassionate and supportive of staff.
- Through the structure of governance papers and talking with staff we saw the leadership of the department reflected the requirement to deliver safe, effective, caring, responsive and well-led services.
- There was an excellent working culture within the department, which was patient focused and interactions with patients were positive. The culture encouraged candour, openness and honesty, and staff told us they were comfortable and not worried to talk to their managers if something had not gone as planned. We saw the outpatient manager thanking staff for their contributions.
- Staff spoke positively about the senior members of the hospital. Staff told us leaders had the skills, knowledge and experience, and they were visible in the outpatient and diagnostic imaging department. One member of staff told us that the hospital director was "a positive, enthusiastic, driven manager… a pleasure to work with… very inspiring, an excellent leader of people". We were told by the physiotherapist that if the manager was not in the department then other senior managers would 'pop into the department' to check that everything was okay. We were also told it was a fantastic place to work – and this was reflected in the patients' feedback – and that the staff 'feel like family'.
- Staff felt listened to. We were told interviewees for vacant posts were introduced and encouraged to talk to

outpatient staff as part of the interview process. Staff were then asked to provide feedback on the interviewees, and this helped to ensure that new members of staff would fit into the team, and that existing members of staff felt part of the process

- Staff in the diagnostic imaging service described a period of unsettled times following the withdrawal of the contract by the clinical commissioning group in October 2014. Three radiographers left the department and some hospital staff were required to reapply for their jobs. Prior to January 2016 there had been no local manager for radiology, and staff had been managed by a regional manager who was based out of the county.
- The radiology manager had been in post since January 2016, and staff described excellent local leadership. Radiographers described them as a strong leader and they appreciated the fact they still spent some time working clinically. Radiographers told us the radiology manager was approachable and their "office was always open".
- Under new corporate and local management, staff felt more stable and substantive appointments had been made. Two of the three radiographers who had previously left returned to work in the radiology department.
- The radiology lead had undertaken a five-day managerial course as well as a root cause analysis course and incident management training.
- There was a sound radiation protection culture and the radiology manager was proactive in educating clinical staff about radiation protection on wards and in theatres.

Public and staff engagement

- We saw that staff at all levels were encouraged and empowered to make changes to improve patients experience, as well as improving working practices. Staff were empowered to make the changes themselves, or lead on initiatives, and were rewarded for doing so.
- Staff were clear that their focus was on improving the quality of care for patients. They felt there was scope and a willingness amongst the team to develop services. We were told by staff that they did not need to wait for meetings if they have an idea to improve the service. If someone had an idea, then they were encouraged to discuss and get on with it. For example, a healthcare assistant told us she had raised a need to redesign the reception desk in outpatients, as files were being mislaid. She was empowered to design the work station herself to ensure that the design worked for the staff. The new system allowed for a better flow of patients through the department, minimising the risk that a patient would be overlooked. The outpatient manager also told us about a member of staff who created a continuity of care form which allowed staff to see when the patient was last reviewed, and what the outcomes were.
- The hospital provided a forum for listening to the views and experiences of patients in order to shape and improve the culture and their care within the hospital. There were systems in place to engage with the public to ensure regular feedback on services, and these systems were used for learning and development. We spoke with members of the patient forum. This group met every six months with the hospital director, medical director and representatives from various staff groups. Patient forum members were asked for their input and feedback on developments within the hospital, such as the introduction of a patient nominated staff award. Forum members were asked to assist with the patient-led assessments of the care environment (PLACE) to assess the quality of the hospital environment, but could only identify minor issues.
- All patients were asked to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the surveys to improve the service and the outpatients waiting area clearly displayed these results. For example, patients had commented that they would like somewhere for relatives to wait, and the hospital provided a family lounge with tea and coffee facilities. The surveys covered the patients' overall satisfaction of experience and how likely they were to recommend the hospital to friends and family if they needed similar care and treatment.
- There were systems to engage with staff. They were able to express their opinions through the staff forum. We saw minutes where the hospital director encouraged staff to challenge their managers to discuss training requirements. Outpatient staff raised an issue regarding lunchtime cover of physiotherapists and it was agreed to stagger lunches to ensure that cover was available. Staff told us that this was an opportunity to have their say and be heard by hospital management, and that they were supported in speaking up.

Outstanding ☆

Outpatients and diagnostic imaging

- We met a domestic supervisor who told us they love their job and the compliments they get from patients about the cleanliness of the hospital, and loves the happy team environment. The domestic supervisor recently introduced their own cleaning schedule throughout the hospital general areas to ensure the assurance of cleanliness was transparent. They also told us they speak to the hospital director on a daily basis and said they felt 'very valued as a team member'.
- A monthly report on patient feedback was produced and shared with the head of nursing and clinical governance manager. The report was reviewed and themes noted and audited with comments acted upon, including improvement in communication. Staff who were mentioned in the feedback were informed and this led to the Physiotherapy team receiving the monthly colleague award following patient comments in October 2015. Feedback was discussed and decimated at Quality governance meetings where complaints, concerns, and compliment were shared with outpatient and diagnostic staff.
- One physiotherapist had started a project called 'The Green Team', which involved a group of volunteer staff and patients to get a working party to improve the environment, identify ways of reducing waste, and reduce the carbon footprint of the hospital. The project was supported by Care UK and encouraged orthopaedic patients to work with staff volunteers to make a garden and improve the local wildlife and environment, as well as creating an opportunity for exercise and social time for patients.
- Clinical managers worked within the departments so they could see for themselves any issues staff faced. Staff confirmed they were visible and approachable.
- There were rewards for staff who had been outstanding. We met a healthcare assistant who had won Employee of the Month after they had updated the electronic system with patient blood results in their own time. They had been given a voucher, and silver Care UK badge at a formal presentation. They told us that it was lovely to get recognition for doing this work.
- We met two members of staff who had left the hospital to pursue others jobs but had returned to work at the hospital due to excellent working relationships, inclusive environment and managerial support.
- Diagnostic imaging staff were well regarded and had excellent relationships with senior managers, the medical director and clinical staff throughout the hospital.

Innovation, improvement and sustainability

- All heads of department had been given budgetary control over their area which allowed for flexibility and autonomy over purchasing.
- Care UK offered a large number of courses and training for staff. In order for larger numbers of the team to access training, train the trainer courses were undertaken and additional local requirements were cascaded in-house which reduced the financial burden of continued professional development for the hospital.
- Radiology worked with the Care UK regional diagnostics lead in order for radiographers to train in ultrasound guided musculoskeletal techniques, Doppler ultrasound and appendicular skeletal reporting.
- The radiology lead had produced a quick reference file for staff with a list of all corporate links, short facts about safeguarding, regulations, CQC key lines of enquires, governance and professional information. This file allowed immediate access to staff of relevant information with the additional documentation being stored electronically. This added to the streamlined processes within radiology.
- The diagnostic imaging manager was responsible for all external contracting for diagnostics, and streamlined the process to ensure all images, bookings and reports were coordinated and available for clinic appointments. This development also offered radiographers a role extension and additional managerial skills.

Outstanding practice and areas for improvement

Outstanding practice

- Cleanliness of the departments was of a high standard, with facilities scoring 100% compliance against cleaning standards.
- The multidisciplinary team working was excellent across all departments and all staff roles. The strong collaboration and support provided was evident during our inspection.
- There was outstanding care provided to the patients. Patients were highly satisfied with the care they received and we observed this in practice.
- Staff recognised and respected people's needs. The hospital was highly responsive to patient's individual cultural and religious wishes.
- The senior management team were visible, approachable and supportive to staff. They encouraged and motivated staff, and embraced innovation at all levels of the organisation.
- Comprehensive risk assessments were used to assess and respond to patient risks, these were recorded clearly on the electronic patient record.
- The extensive audit programme allowed early identification of areas for improvement, action plans were put in place as a result of any non-compliance.
- Staff were fulfilled by the culture in their working environment and felt empowered. They were extremely proud of the organisation and regardless of their role or level of patient contact had the patient care at the centre of everything they did.
- There were clear governance arrangements which allowed the hospital to work in line with best practice and deliver high quality care.
- There was a monthly governance day that all staff were encouraged to attend. This had embedded an understanding of the importance of governance at all levels of the organisation.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure an effective system is in place to verify that all medicines are in date and checked regularly.
- The provider should ensure that the health care risk assessment for pre prepared medication within the anaesthetic room also includes the risk for leaving drawn up medicines unattended in the anaesthetic room, in line with the Royal College of Anaesthetics guidance.
- The provider should ensure that non-compliant flooring in the consulting rooms have been risk assessed.
- The provider should ensure the humidity of the theatres is maintained at an appropriate level.
- The provider should consider displaying the harm-free care NHS safety thermometer results on the ward in line with best practice.
- The provider should consider the accuracy of the process in theatre for recording the completion of the World Health Organisation safe surgery checklist, specifically the potential for errors when inputting the information retrospectively following the check.
- The provider should consider increasing the size of the signs to the ophthalmic clinic.