Foscote Court (Banbury) Trust Limited

The Foscote Private Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Foscote Hospital opened in Banbury, Oxfordshire, in 1981. In October 2014, the hospital came out of a ten-year management contract with a large healthcare company and returned to being independently managed. The Foscote Private Hospital is a charitable trust providing services to patients in Banbury, Oxfordshire and the surrounding areas of, Northamptonshire, Warwickshire, Gloucestershire and Buckinghamshire.

The hospital provides surgical and medical treatments for patients using private medical insurance. Some procedures are offered under the NHS Any Qualified Provider Contract as well as a self-pay option for those patients who prefer to fund themselves.

The on-site facilities include an endoscopy suite, an operating theatre with laminar air-flow and consulting rooms supported by an imaging department offering X-ray and ultrasound. Physiotherapy treatment is offered as an inpatient and outpatient service in its own dedicated and fully-equipped physiotherapy suite. There are 12 patient bedrooms, all with a nurse-call system, en-suite bathrooms, free Wi-Fi access, a television and a telephone.

Services offered include cardiology, cosmetic surgery, dermatology, general medicine, general surgery, gynaecology, ophthalmology, oral & maxillofacial surgery, orthopaedics, rheumatology, respiratory medicine, urology, radiology and physiotherapy. There are no emergency facilities at this hospital.

We undertook a comprehensive inspection of The Foscote Private Hospital in July 2015. At that inspection, we rated the hospital overall as inadequate. Surgery was rated as inadequate and outpatients and diagnostic imaging as requires improvement. We rated safety, effective and well-led as inadequate for the surgical service. This was because the staffing levels, the skills and training levels, working practices in the operating department and medicines were not always safely managed. There was not a consistent approach to the use of national guidance to ensure patients received effective care and treatment. In the operating department, staff were undertaking roles which they were either not qualified for or not assessed as competent to perform.

Governance practices to monitor risk and quality were not embedded across the whole hospital, including in the endoscopy department and theatres. The quality of the service was not being monitored effectively through audit and some working practices were out of line with hospital policies and national guidance. Risks were not adequately identified, assessed or managed.

We undertook an unannounced focused inspection of the surgery service at The Foscote Private Hospital in August 2015. At that inspection, we concentrated on specific areas of noncompliance identified during the comprehensive inspection around surgery. Some improvements had been made, but there had been insufficient changes in the six week period since the comprehensive inspection for these changes to be fully embedded. There was not sufficient evidence to change the ratings applied at the comprehensive inspection and the overall rating of inadequate remained.

We undertook a further unannounced comprehensive inspection of the surgery and outpatients and diagnostic imaging services on 19 January 2016. The inspection team of five included an inspection manager, two CQC inspectors and two specialist advisers, an operating department manager and an infection control lead nurse with outpatients experience.

Our overall rating for this hospital was "good".

Are services safe at this hospital?

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

We rated safety as "good" in both surgery and outpatients and diagnostic imaging.

Summary of findings

- There were sufficient staff in all areas. Staff followed relevant infection control practices and all clinical areas were clean and tidy. All theatre staff participated in the Five Steps to Safer Surgery. Staff had access to the equipment they needed and medical equipment was in date for servicing.
- Staff reported incidents in line with hospital policy and the learning was shared to improve services. Staff understood the principles of openness and transparency that are encompassed within duty of candour.
- Risk assessments for patients were completed and there were processes in place to support patients who became unwell. Staff were able to describe the different types of abuse and understood the importance of raising a safeguarding concern.

Are services effective at this hospital?

By effective, we mean that 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 effectiveness "good" in surgery. We inspected but did not rate effectiveness in outpatients and diagnostic imaging.

- Staff received an annual appraisal and were able to access relevant training to update their clinical skills specific to their roles, such as the surgical first assistant programme. Medical staff were only granted practising privileges to work at the hospital if all pre-employment checks demonstrated they were competent. There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment. Patients' care and treatment was planned and delivered using evidence based guidance, standards and best practice. Staff worked effectively within their teams and across the hospital as a whole to support patient care.

Are services caring at this hospital?

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

We rated caring as "good" in both surgery and outpatients and diagnostic imaging.

- Staff were caring, compassionate, and treated patients with dignity and respect. Patient feedback was universally positive, with patients reporting that staff took the time to talk with them and treated them holistically.

Are services responsive at this hospital?

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

We rated responsive as "good" in both surgery and outpatients and diagnostic imaging.

- There was prompt access to outpatient appointments after referral, both in the daytime and the evening. Patients told us the processes relating to their surgery including booking, admission and discharge had been efficient, and they felt fully informed at each step in the process. Waiting times for surgery from referral were in general four weeks or less. The hospital had strict selection criteria for patients to be accepted for admission, this meant the patient type was carefully managed to ensure that the hospital could meet their needs. he hospital had systems in place to support patients with additional needs, including those living with dementia or with a mobility need. There was an established complaints system. Complaints were investigated and learning shared, with changes implemented as required.

Are services well-led at this hospital?

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

We rated well-led "good" in surgery and in outpatients and diagnostic imaging.

Summary of findings

- Staff were informed about the vision and values for the hospital and were aware of possible development plans for the hospital. Governance processes were overall well developed to manage risks and quality. Although patient outcome data was collected and submitted to a number of national databases, it was not used locally to keep staff informed about how effective care and treatment had been.
- Staff spoke positively about the leadership at a local level and the visibility and support of the senior team. There was an open culture and staff felt they could make suggestions to improve services for patients. Staff acknowledged the last few months had been challenging with all the changes but the culture had changed positively and the hospital was a different place to work at.

Our key findings were as follows:

- Staffing levels on the ward were maintained at a safe level and those in the operating department were in line with national guidance.
- The principles of the Five Steps to Safer Surgery, designed to reduce harm by consistent use of best practice, were being adhered to.
- A full review of hospital polices was being conducted, including a review against national guidance. Systems were in place to monitor practice such as adherence to the Five Steps to Safer Surgery and instrument counts.
- Staff were being supported to develop in their role. For example, staff in the operating department were under taking training to act as a surgical first assistant.
- Most staff were up to date with their mandatory training.
- There was an established system for the servicing and maintenance of equipment. Staff had received training in the use of equipment.
- There was limited storage space in theatres, which meant sterile and non-sterile items were stored together in the same area. Staff had managed the risk by segregation. There was no fume cabinet in theatres to protect staff when using formalin. This risk had been assessed and additional measures were in place to protect staff, while the hospital reviewed the purchasing of a cabinet.
- Medicines were being stored and managed safely.
- Staff followed relevant infection control practices and all clinical areas were clean and tidy.
- Staff were clear about their role and responsibilities under the principles of the duty of candour.
- The hospital had safeguarding procedures, staff had received training and there was a named safeguarding lead.
- Staff were able to define abuse and how to identify adults at risk. They were also clear about the procedures to follow.
- Staff completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff we spoke with had an understanding of how this applied to patient consent but told us they implement the training infrequently as the majority of patients had capacity.
- The hospital submitted patient outcome data to a number of national audits and had subscribed to a national database to enable it to benchmark against other similar services providing private healthcare.
- Staff in different disciplines worked well together. The hospital worked flexibly, including the opening times, according to the needs of their current patient group.
- Staff were caring and compassionate and treated patients with dignity and respect. Patients told us they felt informed about their treatment plan and had been actively involved in decisions about their care. Patients were encouraged to consider their overall wellbeing as part of their treatment plan.
- Patients had prompt access to appointments after referral, with patients able to choose daytime and evening appointments. However, there was not always timely access to test results at follow-up appointments in the outpatients and diagnostic imaging department. This was due to delays in reporting by the provider for this service.
- Patient's pain and the effectiveness of pain management was assessed and monitored.

Summary of findings

- The hospital was responsive to patient needs. A professional interpreter service was available to enable staff to communicate with patients for whom English was not their first language. Patients were provided with written information about their diagnosis or planned procedure. This information was available in languages other than English on request.
- Staff spoke positively about the leadership at a local level and the visibility and support of the senior team. There was an open culture and staff felt they could make suggestions to improve services for patients.
- There was a system for the recording of events, which included incidents. Incidents were investigated and learning shared.
- A review of the committee structure and governance process had resulted in a streamlined reporting system and refreshed committee structure.
- Risks were captured on a risk register, which included action taken to mitigate the risk and was reflective of the risk identified during the inspection.

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

The provider should:

- Introduce a clinical audit programme to monitor the standard of care, treatment and outcomes and take action in response to areas of poor performance.
- Ensure plans for safe handling of specimens in the operating theatre are implemented and ensure the hospital is compliant with any guidance.
- Ensure all staff are up to date with their mandatory training.
- Review the level of training provided for staff in the endoscopy unit and consider the provision of additional training.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	• Theatre staff had made significant changes to improve practices in theatre to ensure they were safe and followed current guidance. This included completing and auditing compliance with the Five Steps to Safer Surgery and ensuring theatre staffing was appropriate for the type of surgery being performed. Areas of concern such as engagement from all staff during the Five Steps to Safer Surgery had been addressed. Staff followed relevant infection control practices and all clinical areas were clean and tidy. Staff had access to the equipment they needed and medical equipment was in date for servicing. • Staff were up to date with their mandatory training and appraisal. Staff could access training to maintain their core skills or complete additional training to develop their role, such as the surgical first assistant programme. Medical staff were only granted practising privileges to work at the hospital if all pre-employment checks demonstrated they were competent. • There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment. Patients' care and treatment was planned and delivered using evidence based guidance, standards and best practice. Nursing staff completed risk assessments for patients on admission and reviewed these as necessary during their stay. In the event that a patient became unwell, there were systems in place for staff to escalate these concerns to medical staff and refer the patient to another hospital if necessary. Care was provided to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system. • Patient feedback was positive. Patients described the excellent quality care they received and how they were treated with dignity and respect. Patients told us they and those close to them, had been involved in making decisions about their care. Discussions with staff were clear and in sufficient depth so they could

Summary of findings

make an informed decision to have surgery. Staff took the time to speak with them and treated them holistically, rather than focusing on just their medical needs.

- Patients told us the booking, admission and discharge process had all been efficient, and they felt fully informed at each step in the process. Waiting times for surgery from referral were in general four weeks or less.
- The hospital had systems in place to support patients with additional needs, including those living with dementia or with a mobility need. There was access to translation services for patients who were non-English speaking.
- Staff were informed about the vision or values for the hospital and were aware of possible development plans for the hospital. Governance processes in the surgery service were overall well developed to manage risks and quality. Staff spoke positively about the leadership at a local level and the visibility and support of the senior team. There was an open culture and staff felt they could make suggestions to improve the service for patients. Staff acknowledged the last few months had been challenging with all the changes but the culture had changed positively and the hospital was a different place to work at.
- There was limited storage space in theatres, which meant sterile and non-sterile items were stored together. The hospital had plans to purchase new racking to address this risk. There was also no fume cabinet in theatres to protect staff when using formalin; the hospital had included this on their risk register and business plan.
- The hospital collected patient outcome data and submitted this to a number of national databases but this data was not used locally to keep staff informed about how effective care and treatment had been, using clinical audit. Staff involved in the surgery service did not meet as a whole team to discuss outcome data.

Outpatients and diagnostic imaging

Good

- Staff reported incidents in line with hospital policy and the learning was shared to improve services. Staff understood the principles of openness and transparency that are encompassed by the duty of candour. Staff followed infection control processes.

Summary of findings

We identified infection control risks in endoscopy, due to the positioning of the decontamination unit. The hospital was aware of this risk and had taken actions to minimise any infection risks. The environment was visibly clean and well maintained, with all clinical areas providing hand-washing facilities and hand sanitiser gels for patients and staff. There were sufficient numbers of staff, but nursing staff in endoscopy raised concerns around the skill mix of staff, in the absence of the lead nurse. Equipment was well maintained and patient records were available for appointments.

- Departments followed national guidelines relating to their service. Patient Reported Outcomes (PROMs) were reported in the physiotherapy department. The endoscopy unit had started reporting quality indicators as part of the Global Rating Scale (GRS), to assess how well they provide a patient-centred service. Staff had received an annual appraisal and were able to access relevant training to update their clinical skills, specific to their roles. Staff worked effectively within their teams and across the hospital as a whole to support patient care.
- Staff were caring and compassionate and treated patients with dignity and respect. Patients told us they felt informed about their treatment plan and had been actively involved in decisions about their care. Patients were encouraged to consider their overall wellbeing as part of their treatment plan.
- There was an interpretation service for people for whom English was not their first language and the hospital was accessible to those with a disability. There was prompt access to appointments after referral, both in the daytime and the evening. Friends and Family Test scores were positive.
- Staff were informed about the vision or values for the hospital and were aware of possible development plans for the hospital. Governance processes in the outpatients department, endoscopy and diagnostic imaging were overall well developed to manage risks and quality. Staff spoke positively about the leadership at a local level and the visibility and support of the senior team. There was an open culture and staff felt they could make suggestions to improve services for patients.

The Foscote Private Hospital

Detailed findings

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Detailed findings

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Background to The Foscote Private Hospital

The Foscote Private Hospital is a charitable trust providing services to patients in Banbury, Oxfordshire and the surrounding areas of Northamptonshire, Warwickshire, Gloucestershire and Buckinghamshire. The hospital provides surgical and medical treatments for patients. The on-site facilities include consultation rooms, an imaging department offering X-ray and ultrasound, an endoscopy suite and an operating theatre with laminar air-flow. There are 12 patient bedrooms with en-suite facilities.

The Foscote Hospital opened in Banbury, Oxfordshire, in 1981. The hospital came out of a 10 year management contract with a large healthcare company in 2014 and returned to being independently managed. We undertook a comprehensive inspection of The Foscote Private Hospital in July 2015. At that inspection, we rated the hospital overall as inadequate. Surgery was rated as inadequate and outpatients and diagnostic imaging as requires improvement. We rated safety, effective and well-led as inadequate for the surgical service. This was because the staffing levels, skill mix, staff training and working practices in the operating department were not safe. Also, medicines were not always safely managed.

There was an inconsistent approach to the use of national guidance to ensure patients received effective care and treatment. In the operating department, staff were undertaking roles, which they were either not qualified for or not assessed as competent to perform

Governance practices to monitor risk and quality were not embedded across the whole hospital, including in the endoscopy department and theatres. The quality of the service was not monitored effectively through audit and some working practices were out of line with hospital policies and national guidance. Senior management did not adequately identify, assess or manage risks.

After this inspection in July 2015, we served three warning notices against the hospital under "staffing" and "safe care and treatment" for the regulated activity surgical procedures. The third notice was served under "governance" for the regulated activities surgical procedures and treatment of disease, disorder or injury. The warning notices required the hospital to take

immediate action to improve the safety of patient care and address the staffing levels and training needs of staff in the operating department. Changes were required to governance processes to identify, assess and manage issues around quality and risk at the hospital.

We undertook an unannounced comprehensive focused inspection of the surgery service at The Foscote Private Hospital in August 2015 to follow-up on the warning notices served. At this inspection, we found improvements in some areas, however there remained concerns around the governance processes. A further warning notice was issued under "governance" for the regulated activities surgical procedures and treatment of disease, disorder or injury. After the inspection, there was not sufficient evidence to change the rating applied at the comprehensive inspection, therefore the overall rating for the hospital remained inadequate.

Governance procedures and processes were not effective in the operating department or across the hospital as whole. We found staff in the operating theatre had made

Detailed findings

improvements, with the support of senior management, but we still had concerns about patient safety. Theatre staffing did not always meet national guidance. Instrument counts were completed, but the Five Steps to Safer Surgery was not yet part of normal practice. Medicines management had improved and staff had received training to safely use equipment.

Policies referenced relevant national guidance, but staff did not fully appreciate the benefit of this guidance in respect of the treatment outcomes for the patient.

However, staff acting as surgical first assistant (SFA) were following a national training programme. Competency assessments were in place for the staff in the operating department.

We undertook this unannounced comprehensive inspection of the surgery and outpatients and diagnostic imaging services at The Foscote Private Hospital, in January 2016, to follow-up on the warning notice served.

The registered manager is Karen Ruth Thompson (Ruth) who has been in post since October 2014.

Our inspection team

Our inspection team was led by:

Inspection Manager: Lisa Cook, Care Quality Commission (CQC)

The inspection team of five included an inspectionmanager, two CQC inspectors and two specialist advisers,an operating department manager and an infectioncontrol lead nurse with outpatients experience.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital. We carried out an unannounced inspection visit on 19 January 2016.

During this unannounced comprehensive inspection, we assessed both the surgical service and outpatients. We also reviewed the overall governance processes for the hospital and reported on this as part of the well-led domain. We spoke with 30 members of staff and nine patients, observed patient care, looked at seven patients' care and treatment records and at hospital policies.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at The Foscote Private Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Surgery

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

Information about the service

Surgery is the primary inpatient activity of The Foscote Private Hospital. Cosmetic surgery, general surgery, gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedics and urology surgery are performed. There were 1,189 admissions for surgery from January to December 2015. The three most commonly performed procedures were phacoemulsification of lens with implant (103), primary repair of inguinal hernia (98) and multiple orthopaedic operations on knee (48).

The hospital has one operating theatre with a single-bedded recovery area. There are 12 patient rooms over two floors, all the rooms are single with an en-suite.

There is a pre-operative assessment clinic room and a bookings and administration office.

We inspected theatres, the ward area and the pre-assessment clinic. We spoke with three patients and 12 members of staff, including theatre and nursing staff, a consultant, an anaesthetist and the resident medical officer. We also checked two pieces of equipment, reviewed two sets of patient records, one personnel file and observed care on the ward, in the operating theatre and in the recovery area.

Summary of findings

Overall, we rated this core service as "good". We found the surgery service to be good for safe, effective, caring, responsive and well-led.

- Theatre staff had made significant changes to improve practices in theatre to ensure they were safe and followed current guidance. This included completing and auditing compliance with the Five Steps to Safer Surgery and ensuring theatre staffing was appropriate for the type of surgery being performed. Areas of concern such as engagement from all staff during the Five Steps to Safer Surgery had been addressed. Staff followed relevant infection control practices and all clinical areas were clean and tidy. Staff had access to the equipment they needed and medical equipment was in date for servicing.
- Staff were up to date with their mandatory training and appraisals. Staff could access training to maintain their core skills or complete additional training to develop their role, such as the surgical first assistant programme. Medical staff were only granted practising privileges to work at the hospital if all pre-employment checks demonstrated they were competent.
- There was good multidisciplinary working across all teams in the hospital so patients received co-ordinated care and treatment. Patients' care and treatment was planned and delivered using evidence based guidance, standards and best practice. Nursing staff completed risk assessments for patients

Surgery

on admission and reviewed these as necessary during their stay. In the event that a patient became unwell, there were systems in place for staff to escalate these concerns to medical staff and refer the patient to another hospital if necessary. Care was provided to inpatients seven days a week, with access to diagnostic imaging and theatres via an on-call system.

- Patient feedback was positive. Patients described the excellent quality care they received and how they were treated with dignity and respect. Patients told us they and those close to them, had been involved in making decisions about their care. Discussions with staff were clear and in sufficient depth so they could make an informed decision to have surgery. Staff took the time to speak with them and treated them holistically, rather than focusing just on their medical needs.
- Patients told us the booking, admission and discharge process had all been efficient, and they felt fully informed at each step in the process. Waiting times for surgery from referral were in general four weeks or less.
- The hospital had systems in place to support patients with additional needs, including those living with dementia or with a mobility need. There was access to translation services for patients who were non-English speaking.
- Staff were informed about the vision or values for the hospital and were aware of possible development plans for the hospital. Governance processes in the surgery service were overall well developed to manage risks and quality. Staff spoke positively about the leadership at a local level and the visibility and support of the senior team. There was an open culture and staff felt they could make suggestions to improve the service for patients. Staff acknowledged the last few months had been challenging with all the changes but the culture had changed positively and the hospital was a different place to work at.
- There was limited storage space in theatres, which meant sterile and non-sterile items were stored together. The hospital had plans to purchase new racking to address this risk. In addition, there was no fume cabinet in theatres to protect staff when using formalin; the hospital had included this on their risk register and business plan.
- The hospital collected patient outcome data and submitted this to a number of national databases but this data was not used locally to keep staff informed about how effective care and treatment had been, using clinical audit. Staff involved in the surgery service did not meet as a whole team to discuss outcome data.

Surgery

Are surgery services safe?

Good

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

We rated safe as "good".

During our inspection in August 2015 we found:

Theatre staffing did not always meet national guidance, instrument counts took place, but not always with a silent focus from the whole team and staff had not embedded the Five Steps to Safer Surgery as part of their normal practice. Staff had limited understanding of Duty of Candour and were not confident in defining a safeguarding incident. Staff had received training on the equipment used in theatres and daily equipment checks were taking place.

During this inspection we found:

- Theatre staff had made significant improvements to improve patient safety. The hospital consistently staffed the theatre in line with current guidance. All theatre staff participated in the Five Steps to Safer Surgery and regular audits took place to monitor performance, with actions identified to improve compliance.
- Staff had completed training on Duty of Candour and could describe what this meant and what their role in the process would be. Staff were up to date with their mandatory training and understood the importance of raising a safeguarding concern. They could describe the different types of abuse. Staff knew how to report an incident and learning was shared at team meetings.
- Risk assessments for patients were completed and there were processes in place to support patients who became unwell. Staff told us there was good access to support from medical colleagues.
- Clinical areas were clean and tidy. Staff followed infection control procedures and practices to minimise the spread of infection to patients. There was sufficient medical equipment and good levels of stock for single use items. Medical equipment had been serviced but the company providing this had not fully updated the hospital database. The hospital manager had contacted them about this.

However:

- Storage space in the operating department was at capacity, which meant some sterile and non-sterile packaged items were stored in the same store rooms.
- There was no fume cabinet in theatre for staff to use when working with hazardous materials, however, the hospital had identified this as a risk and put mitigating steps in place. Incidents
- The hospital had recently introduced and was using a new electronic reporting system for staff to report and record all events, including incidents. The event system also captured information on the number of complaints, safeguarding referrals, never events, serious incidents and accidents. Heads of departments had received training on the new system and were planning to teach the staff in their team. Staff could also access an online training guide to the new system. Staff who had not completed their training, told us they would ask a colleague for help using the new system or raise the incident with their manager.
- Heads of departments understood their role in the investigation of incidents and shared relevant learning at team meetings, or if more urgent at daily handovers. Heads of departments also discussed learning across the service at the monthly quality and risk meetings.
- Staff who had used the new system told us it was easier to use than the previous paper based system. Staff knew when to report an incident and felt confident to do this. A member of staff described an incident they had reported where the hospital had cancelled a patient's operation due to an insufficient number of theatre staff. They had also spoken with the patient and offered an apology.
- Staff confirmed that feedback on incidents was disseminated during team meetings, to share learning and improve patient outcomes. Minutes of quality and risk meetings showed the themes of incidents were discussed and fed back to staff. Staff were aware that they could access minutes from the quality and risk meetings. These were kept in the staff room and on the hospital shared drive computer access system, which all staff had access to.
- There were 33 recorded events across the hospital between October and December 2015; three were graded as moderate impact, the rest as low impact. Eighteen events had occurred on the ward and seven

events in theatre. These had all been reported on the new events system. The hospital planned to revise the events management report to show the type of events which occurred in each area.

- All nursing staff we spoke to had received training on Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff understood their responsibility to be open and honest with a patient and their family when something had gone wrong. Senior staff understood their role in investigating a notifiable safety incident and the importance of keeping a patient informed and offering support.

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

- The hospital monitored its safety performance through use of the safety thermometer. The safety thermometer provides a monthly snapshot audit of the prevalence of avoidable harms that occur including pressure ulcers, falls, venous thromboembolism and catheter related urinary tract infections. The percentage of patients receiving harm free care is also reported.
- The hospital displayed safety thermometer information at the entrance to the ward, so patients and staff could see the figures for the previous month.
- Data for August 2015 to January 2016 showed no avoidable harms had occurred and 100% of patients had received harm free care each month.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and tidy.
- There were cleaning schedules in use on the ward and in the operating department. We saw certificates for 2015, confirming that a six monthly deep clean had taken place in theatres.
- In all clinical areas and some patient rooms vinyl flooring was in place to ensure floors could be thoroughly cleaned to maintain good hygiene standards. Some corridors were carpeted, the hospital planned to address this in due course and also replace all carpets in patient rooms to easy clean vinyl flooring.
- We observed staff following good infection control practices, such as cleaning their hands before and after patient contact and ensuring they were 'bare below elbows', to minimise the risk and spread of infection to patients. Staff also had access to personal protective equipment such as gloves and aprons, which we observed them using appropriately.
- Infection control observation audits took place regularly across the ward and theatres, these included hand hygiene, peripheral intravenous cannula care, urinary catheter care and care bundle to prevent surgical site infection. Results for October and November 2015, showed compliance was 100% for all audits completed.
- From January to December 2015, there had been one case of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) and no cases of Clostridium difficile. The MRSA case had been investigated and changes made to practice, including patients using a specialist body wash prior to and on the morning of their surgery, to reduce the risk of surgical site infection. This was in accordance with National Institute for Health and Care Excellence guidance CG74 Surgical site infections: prevention and treatment.
- The hospital screened patients for MRSA as part of their pre-operative assessment. Pre-assessment staff often had to chase for this and other test results. The senior management were having ongoing discussions with the provider of this service to improve response times and ensure patients with MRSA were treated prior to surgery.
- On the ward, new posters had been placed around the hand sanitiser dispensers to make them more visible, and to encourage staff and patients to wash their hands. There were also hand sanitiser dispensers in each patient room.
- There was no hand sanitiser dispenser at the entrance to the operating department. It was located on the wall as you entered the department. We observed two visitors who did not clean their hands prior to delivering supplies. There was a potential infection risk due to the hand sanitiser point not being in a prominent position.
- The theatre manager told us there were plans to purchase a new racking system for two of the storerooms, to improve how items were stored and enable more effective cleaning. The current layout meant there was a mix of sterile and non-sterile items in the same storeroom, with some non-sterile items stored in the outer packaging, such as a cardboard box. This was not considered best practice and had been highlighted as a concern in the report from the Association for Perioperative Practice (AfPP) during their review of theatres in December 2015. This risk was on

the theatre risk register with an expected completion date of September 2016. Currently, sterile and non-sterile items were segregated within each storeroom to minimise the infection risk.
- The hospital had a service level agreement with a local NHS hospital for the decontamination of surgical equipment. Surgical packs had a unique tracking number. The theatre manager described the process for tracking packs and we saw the written records kept by the hospital so they could trace a pack if necessary.

Environment and equipment

- Staff told us there was sufficient equipment for them to care for patients and stock levels were well maintained for both reusable and single use items.
- There were four storage rooms in the operating department, which were well stocked, but there was limited space for more items. In one room, there was equipment, sterile items and a trolley containing a surgical pack for each patient having an operation that session. There was insufficient space to put each pack on a separate trolley to avoid items becoming mixed up. The hospital was considering an extension to the operating department to increase storage and office space.
- Staff understood their responsibility to ensure clinical waste was segregated and disposed of appropriately. Clinical waste bins were clearly labelled and we observed the rooms used to store clinical waste were kept clean and tidy to minimise infection risk.
- There was no fume cabinet in the theatre to protect staff when using formalin to preserve specimens. This is a requirement of the Control of Substances Hazardous to Health 2002 legislation. The hospital had identified this as a risk and provided respirators for staff to use. Staff health screening was to take place in February 2016 and the hospital business plan included costings to purchase a cabinet.
- We checked two pieces of medical equipment; they had been recently serviced and were clearly labelled with the interval and due date of the next service. An external company arranged servicing of equipment for the hospital. Although they had serviced equipment, they had not updated the database accessed by staff, which suggested equipment was overdue a service. The hospital manager had made the company aware of this.
- Records for daily and weekly checks of the resuscitation trolleys were reviewed for the last month and were complete. There was a list with each trolley to show when items were due to expire, to ensure items were kept in date and ready to use in an emergency.
- At the inspection in July 2015, checks of the 'difficult intubation trolley' were not recorded to confirm all equipment was accessible and in date. The trolley contained equipment for staff to use in a patient airway emergency. During this inspection we found daily checks were now recorded when the theatre was open. A laminated list was also attached to the trolley to show where items could be found.
- We observed staff safely using the correct equipment to transfer a patient in the operating theatre.

Medicines

- Medicines were safely managed on the ward and in theatre.
- Medicines, including controlled drugs, were stored securely on the ward and in theatre. Nursing staff could describe the procedure to follow for the issuing of and documentation required for controlled drugs. The controlled drugs book in the anaesthetic room had been completed and signed as per hospital policy.
- Medical gases were safely and securely stored. The hospital was sourcing a separate cage where empty cylinders could be stored, so it would be clear to staff which was current stock. Maintenance staff responsible for the management of medical gases told us they had received additional training, for their own and patient safety.
- We checked four medicines and all were in date. Stock in the anaesthetic room medicines cupboard was stored in date order, with the shortest date item at the front. Staff kept written records in the medicines cupboard to show when items were due to expire.
- Staff completed fridge temperature checks daily to ensure medications were stored safely. The theatre record was complete and up to date.
- The medicines management audit for November 2015 for theatre had identified that agency staff had not completed the recording of fridge and ambient room temperature on two days, a reminder had been given to all staff. On the ward 100% compliance had been achieved.
- The hospital had a contract with a local pharmacy service. A pharmacy technician was on site three days a

week, to monitor stock levels and a pharmacist visited monthly to provide oversight of prescribing. Outside of these times, the hospital could contact pharmacy staff by phone for advice. The ward sister told us this system worked well.

Records

- We looked at two sets of patient records. Both sets where complete and contained up-to-date pre-operative assessments, anaesthetic and surgery notes, observation charts, nursing assessments and care plans. We observed staff completing patient records at the point of contact with the patient or shortly after, to ensure they kept the patient record up-to-date.
- Staff wrote the majority of their observations and notes in the pathway document, which contained information from pre-admission through to discharge and was an easy point of reference.
- Risk assessments, such as the risk of falls or malnutrition, were completed by staff and were included in the pathway document. Recent outpatient letters were also kept in the patient record for reference if needed, during admission or surgery.
- A recent records documentation audit showed for October 2015 showed overall compliance of 80 to 90%. A specific area identified in the audit showed theatre staff were writing the date but not always writing the time by each entry in the patient record (only 10% of staff included the time). The hospital audit action plan advised this would verbally be fedback by the team leader to staff. The November 2015 audit showed improved compliance with recording the time in the patient record (60%), but still not 100% compliance.
- Patient records were stored in the nursing office on the ward, to maintain confidentiality and security of patient records.

Safeguarding

- The hospital had a safeguarding children and adults at risk policy. The hospital did not provide inpatient services for children under 18, but did see children aged 16-18 as daycases. It was important staff were able to recognise a child at risk, and know how to raise concerns, should a child attend with a family member or carer during an appointment or visit. The hospital manager was the named person for safeguarding. The policy described what could place an adult or child at risk and the different types of abuse. There was also a flow chart indicating the action staff should take if they identified concerns.
- Training data from the hospital showed as of December 2015, 91% of staff in theatre and 93% of staff on the ward had completed their safeguarding children training (level 2) and 100% of staff in theatre and 94% of staff on the ward had completed safeguarding vulnerable adults training (level 2). Staff had to complete this as part of their induction training and then an update annually.
- At our inspection in August 2015, staff in the operating department were not confident in describing the different types of abuse. During this inspection, we spoke to two members of theatre staff who told us they had completed their training and felt confident to raise a concern. They could describe the different types of abuse and the process they should follow to raise a concern.

Mandatory training

- Staff told us and training records from the hospital showed, staff were up to date with their statutory and mandatory training. As of December 2015, compliance with the training modules was between 90 to 100% for theatre and ward staff, for 13 out of 17 modules. The number of staff from theatre who had completed their hand hygiene and infection prevention training was 67%, this was better for the ward with 81% of staff having completed this training. The number of staff having completed intermediate life support training on the ward was lower than expected at 69%, for theatre staff this was better at 82%. New staff joining the hospital that had not completed all their mandatory training and staff sickness had affected the compliance rate. The provider was unable to provide a target for expected training compliance.
- The statutory and mandatory training included modules on information governance, infection control and manual handling. A matrix was used to show which training staff needed to compete depending on their role.
- Staff told us they completed the majority of their training online, through e-learning packages. They had

time to complete their training and there were now more computers available for them to use. Staff received email updates so they knew which modules they needed to complete and by when.

Assessing and responding to patient risk

- Staff completed risk assessments for patients as part of the pre-admissions process and on admission to ensure potential risks were identified and managed.
- The hospital had strict criteria for patients who would be suitable for surgery at the hospital. This was to make sure there were the required facilities to care for patients, before and after their surgery. Staff running the pre-admission clinic knew the criteria and declined any patients who were not appropriate. The resident medical officer (RMO) reviewed results from pre-admission tests and discussed any concerns with the patients' consultant or the anaesthetist, prior to surgery going ahead.
- Risk assessments such as risk of falls, malnutrition and pressure ulcer development were part of the patient pathway. Staff completed a care plan for areas identified as a risk. We saw in patient notes that staff had reviewed these risk assessments and care plans, the frequency dependent on the level of risk. Staff also used the National Early Warning System (NEWS) to monitor key patient signs, such as temperature and blood pressure. The score obtained determined the frequency of further observations and the clinical response required. The process for staff to follow was clearly written on the NEWS record chart.
- Theatre staff completed the Five Steps to Safer Surgery, compliance with this and completion of the World Health Organisation (WHO) surgical safety checklist, was included in the patient pathway and audited. Audits had identified some consultants not ensuring a silent focus during each step. The chair of the medical advisory committee (MAC) had since written to all surgeons and anaesthetists and this had improved. Theatre staff had also been encouraged to speak louder during the instrument counts. Two observational audits, completed in theatres for December 2015, showed 100% compliance.
- We observed one session in theatre. The Five Steps to Safer Surgery checklist was completed in full, with all staff engaged for each stage, the sign in, time out and sign out. Swab and instruments counts were audible and there was a silent focus from all staff during the count. At the previous inspection, staff had not completed all steps of the checklist and staff were talking during the instrument count, potentially putting patients at risk.
- The anaesthetist remained on site until all patients had stabilised after their operation. There was an anaesthetist on call overnight in case of any concerns. Each consultant identified a colleague who would be on call for their speciality each day, if they had any patients staying overnight and the consultant was not available to be contacted.
- The hospital had a deteriorating patient pathway for patients who became unwell. This required nursing staff to monitor and record a patient's vital signs using NEWS, liaise with the RMO who had responsibility for stabilising the patient and then arranging referral to a local NHS acute hospital. Nursing staff and the RMO were aware of the correct process to follow to ensure prompt and timely intervention for a patient who required additional medical treatment.
- All staff had completed training on using a defibrillator, with nursing and theatre staff completing intermediate life support training and the RMO advanced life support training. The RMO would take the lead should a patient suffer a cardiac arrest. Staff took part in simulation exercises to review the team response to an emergency situation. Verbal and written feedback was given to staff and any necessary improvements made.
- Nursing staff called all patients 48 hours after their operation to see if they had any difficulties with their recovery and to enable them to ask any questions. This information was recorded in the patient record.

Nursing staffing

- The number and skill mix of nursing staff in theatre and on the ward was appropriate for the number of patients and their needs, on the day of our inspection. On both previous inspections, there had been an insufficient number of staff in theatre.
- The theatre manager and deputy planned their staffing rota based on best practice guidance from the AfPP 2014. The minimum requirement was five qualified theatre staff for each theatre session, two scrub practitioners (reduced to one if there was only one major case), one circulating practitioner, one anaesthetic assistant practitioner for each session involving an anaesthetic, one circulating practitioner

and one post anaesthetic recovery practitioner. Staff acting as a surgical first assistant were an additional member of the team, unless they were performing a dual role, acting also as a scrub practitioner.

- We reviewed the theatre management policy (December 2015) which included detailed information on how the theatre should be staffed which was in line with current guidance from the AfPP.
- We checked the staffing rotas for the three weeks prior to the inspection and all sessions were staffed as per the AfPP guidance, taking into account the surgical procedures, which were being performed. The hospital manager also audited the rotas to ensure there were safe staffing levels in theatre. The rota now clearly identified who was acting as surgical first assistant. For one of the three weeks, the rota had shown the number of cases per day and whether they were major or minor procedures. This made it easier to identify the number of staff needed. This good practice had not been used for the other two weeks.
- The operating department staff provided an on-call service, in case a patient staying overnight had to be readmitted to theatre as an emergency.
- For the ward, there were always two registered nursing staff on duty for each shift. Actual staffing levels on the day of inspection were as planned for each shift. If there were no patients at the hospital, there was always one member of nursing staff on duty, to answer patient phone calls about their surgery. This member of staff worked with the RMO. If only outpatient clinics were running, two nursing staff were present on the ward, in case an emergency situation arose and a patient needed care and treatment. Staff worked flexibly to ensure there were enough staff on duty to meet the needs of patients.
- For both teams the use of agency staff was kept to a minimum. Staff told us there was an induction programme for agency staff.

Surgical staffing

- Consultants working at the hospital led and delivered the surgical service.
- Nursing and theatre staff told us they could contact any consultant, out of hours or when not on-site, if they needed advice about the best care and treatment for a patient. They told us they had a good working relationship with the medical staff. Each consultant identified a colleague who would be on call for their speciality, if they had any patients staying overnight and the consultant was not available to be contacted.
- There was a RMO on-site 24 hours a day. They conducted a ward round every 12 hours with the senior nurse, to review all inpatients. If the RMO had any concerns, they would speak with the consultant responsible for the patient. The RMO also responded to emergency calls and was advanced life support trained.
- The ward sister ensured each new RMO had a local induction programme to the ward. They also tested the RMO bleep each morning, to ensure they came to the correct location when contacted.
- Patients told us the consultant and anaesthetist had seen them prior to having their surgery.

Major incident awareness and training

- The hospital had a business continuity plan that included the process for staff to follow in the event of a major incident, such as a fire or flood. This were supported by 'Action cards' which were quick reference guides for staff, containing key action points and useful contact names and phone numbers.
- Fire evacuation information was displayed in the operating department staff room, so staff could remind themselves of their role, in the event of a fire. Staff completed fire safety training as part of the mandatory training.

Are surgery services effective?

Good

By effective we mean that 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 effective as "good".

During our inspection in August 2015 we found:

The hospital had introduced competency assessments for theatre staff. Staff acting as a surgical first assistant had started a recognised training programme and staff assisting the anaesthetist had an appropriate level of training.

During this inspection we found:

- Staff followed relevant national guidance when providing care and treatment to patients. Systems were in place to monitor and act upon any updates to best practice guidance. The hospital submitted patient outcome data to a number of national audits and had subscribed to a national database to enable it to benchmark against other similar services providing private healthcare. The few procedures performed meant the service could not always directly compare its outcomes.
- Staff were up to date with their appraisals and supported to access further training for their role. Staff undertaking additional roles such as surgical first assistant followed a recognised national competency based programme. The hospital had a robust system in place to grant practising privileges to consultants wishing to work at the hospital. In instances of poor performance, the practising privileges were removed.
- Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs. Discharge planning started during the pre-assessment process to ensure patients were discharged with all the support they needed and at the right time.
- Patients told us they had made an informed decision to give consent for surgery. They could access pain-relieving medication as needed post-surgery and the quality of the food was good.
- The hospital had systems in place to ensure care was provided for inpatients seven days a week, including access to on-call theatre and medical staff in an emergency. Planned operations were performed only during the week.

However:

- There was no local clinical audit programme in place to monitor, discuss and change practice in response to patient outcomes.
- Test results were not always returned promptly by the external provider for this service. Nursing staff spent time chasing results to ensure they were available prior to surgery.

Evidence-based care and treatment

- Care and treatment for patients was planned and delivered using relevant national guidance, standards and best practice recommendations.
- The hospital devised the short and long stay patient pathway document based on best practice recommendations from a number of professional bodies including the Joint Advisory Group on Gastro-Intestinal Endoscopy and British Association of Day Surgery.
- Staff running the pre-operative assessment clinic followed the National Institute for Health and Care Excellence (NICE) guidance CG3 Preoperative tests, to ensure patients had relevant tests performed prior to surgery, to minimise the risk of complications or harm. Theatre staff followed NICE guidance (QS49) Surgical site infection. This included steps to follow to minimise the risk of infection during surgery. Staff recorded completion of these steps in the patient pathway document. This information was audited as part of the Five Steps to Safer Surgery.
- The Theatre Management Policy referenced guidance from the Association for Perioperative Practice (AfPP) on staffing in theatres. The hospital reviewed and audited staffing rotas to ensure compliance with the policy.
- Staff could access guidance such as NICE on the hospital computer system. The hospital received email alerts when NICE guidance had been updated, so staff could review and amend policies and practices as needed.

Pain relief

- All patients told us staff had asked about and assessed their level of pain at various stages during their stay in hospital. They had been given medication promptly to manage any pain they were experiencing.
- We looked at two sets of records; for both patients, staff had completed a pain management plan and given patients written information at the pre-assessment clinic about how to manage any pain once they were home. Pain scores had been recorded and acted on appropriately by staff during the patients' stay in hospital.
- Nursing staff told us they contacted the consultant for the patient, if they had significant concerns about the pain a patient was experiencing. The consultant provided advice to either the nursing staff or the resident medical officer (RMO) so the patient could receive additional pain reliving medication or had a medical review by the RMO.

- A member of the nursing team was the pain link nurse. They reviewed guidance such as NICE, to ensure patients were receiving evidenced based care and treatment.

Nutrition and hydration

- The malnutrition universal screening tool was completed as part of patient risk assessments. This is used to identify patients at risk of malnutrition. A dietician could be contacted for additional advice if needed.
- Patients were monitored for nausea and vomiting, which was recorded in the patient pathway. Staff gave anti-sickness medication to patients as needed.

Patient outcomes

- The hospital participated in a number of national audits including the Patient Reported Outcome Measures questionnaire, which reports on outcomes for patients undergoing surgery for hip and knee replacements, groin hernia and varicose veins. The hospital submitted outcome data, which enabled them to compare their outcomes to other similar services. The hospital also submitted data to the National Joint Registry. However, there was no evidence in minutes from the medical advisory committee meeting or quality and risk meeting, that these outcomes were discussed so action could be taken if outcomes were not as expected.
- Provisional PROMs data for April 2014 to March 2015 showed a favourable outcome for patients having a hernia repair at the hospital. However, direct comparison could not be made to other centres as fewer than 30 procedures were performed. There was no PROMs data for hip or knee surgery due to insufficient procedures being performed. The hospital had also recently joined the Private Health Information Network (PHIN). PHIN planned to provide information for the public from April 2017 on 11 key performance measures, so a patient could make an informed choice where to have their care and treatment for providers offering privately funded healthcare.
- The hospital benchmarked their outcomes against other services where possible and considered different audits or groups they could join to improve this.
- The hospital monitored unplanned returns to theatre, unplanned readmissions and unplanned transfers to another hospital. For January to December 2015, there had been three returns to theatres, five readmissions and four unplanned transfers to another hospital, from a total of 1189 operations performed. There was no national comparable data for this.

Competent staff

- Theatre and ward staff told us they had time and support to access additional training for their role. The majority of staff were up-to-date with their appraisal, five out of seven theatre staff and nine out of 11 nursing staff had received an appraisal in the last 12 months. Some staff had only recently started their role.
- The infection control lead had sourced additional training for their role and planned to share key learning with staff across the hospital.
- Theatre staff working as a surgical first assistant were supported by the hospital to complete a recognised external competency based qualification for their role, in line with guidance from the Perioperative Care Collaboration. They had support from a mentor and consultant while completing this training.
- The ward manager was reviewing the competencies used to assess ward staff, as they felt they needed to be in more detail, to demonstrate staff could complete their role confidently.
- Employees from medical supply companies provided training to staff on equipment, a record was kept of training staff had completed, to demonstrate staff competencies.
- Theatre and nursing staff valued the training session provided by consultants, they had provided training recently on hernias and pain management.
- An external nurse specialist was supporting the registered nursing staff preparing for the new national revalidation process. The hospital was developing a new competency framework and appraisal process. The current competency framework relied on self-assessment; the hospital vision was that the new system would include a mixture of self-assessment and observation, to be reviewed and discussed at the individual's appraisal.
- Clinical heads of departments monitored the registration status of their staff to ensure it was current. They told us all staff were registered appropriately in their department.

- Senior management completed a number of checks prior to granting consultants practising privileges at the hospital. The term 'practising privileges' refers to medical practitioners being granted the right to practice in a hospital.
- In order to maintain their practicing privileges consultant medical staff were required to supply copies of current insurance, a disclosure and barring scheme check, hepatitis B status, their registration, last appraisal for their main place of work, information verifying scope of practice and revalidation date.
- We saw in the minutes from the Medical Advisory Committee (MAC) that decisions to grant or stop practicing privileges had been discussed and appropriate action taken, where the MAC had identified concerns about performance or conduct.
- The RMO induction included a week shadowing the current RMO so they had an opportunity to familiarise themselves with the hospital's procedures. They also completed some mandatory training modules including fire awareness training and infection control.

Multidisciplinary working

- Throughout the inspection, we observed good multidisciplinary working between the different teams involved in a patient's care and treatment. There was clear communication between staff from different teams, such as the anaesthetist, anaesthetic nurse and theatre staff to ward staff.
- A member of staff on the ward described the positive working relationship with the pharmacy service, which was outsourced by the hospital. Pharmacy staff were easy to contact for advice and provided an efficient service when working at the hospital.
- The RMO attended the nursing handover, which they said was useful and informative.
- Physiotherapy staff worked with the consultants to co-ordinate a care plan for the patient.
- Nursing and theatre staff told us it was easy to contact a consultant if they needed advice. Staff told us everyone worked together well as a team throughout the hospital, to provide good care and treatment for patients.
Seven-day services
- Planned operations took place Monday to Friday, no operations were planned at the weekend. However, theatre staff and an anaesthetist were on-call should there be an unplanned return to theatre.
- The RMO was on-call at all times and was based at the hospital, should staff need to escalate concerns about a patient. The hospital always had a member of nursing staff on duty to answer the phone, in case of queries or concerns out of hours.
- If a patient needed an urgent imaging scan out of hours, the hospital had a service level agreement with the local NHS hospital. The RMO or consultant contacted the hospital to arrange this. The radiology department provided an on-call service outside normal working hours and at weekends.
- Inpatients requiring physiotherapy had two sessions a day during the week and one session over the weekend.

Access to information

- No staff raised any concerns around access to patient information such as patient records; they told us these were available for surgery. However, nursing staff running the pre-assessment clinic raised concerns around the time taken for test results, such as blood tests and scans, to be returned to the hospital. This service was outsourced to another provider. They often had to call the provider and chase results so that planned operations could go ahead.
- The hospital had completed two audits in April and September 2015 looking at the response time for test results. The most recent audit showed results were generally reported on the same day, but there was a delay in the provider sending the results. There were also issues with staff being unable to open email attachments containing test results. Staff were unable to directly access the reporting system used by the organisation providing the service.
- The use of the patient pathway document enabled different teams to access key information about the patient. Notes were hand written and were accessible to all staff, including agency staff. All the relevant information for each patient such as outpatient clinic letters, surgery records and observational charts were all stored in one file for ease of access.
- A discharge letter was sent to the patients' GP; staff recorded this had been completed in the patient pathway document.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us they had been able to make an informed decision about surgery, before signing the

consent form. The consultant discussed the risks and benefits of surgery with them and these were included on the consent form. The two consent forms we checked confirmed this.

- Compliance with completion of consent forms was checked as part of the notes documentation audit. The audit from October 2015 had found one out of 20 records did not have the second stage completed on the day of surgery. Heads of departments made staff aware of this. The audit the following month showed 100% compliance.
- Relevant staff groups completed consent training as part of their mandatory training. All theatre staff and 94% of ward staff had completed this training as of December 2015.
- Staff completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. Staff we spoke with had an understanding of how this applied to patient consent but told us they implement the training infrequently as the majority of patients had capacity. All theatre staff had completed this training and 89% of ward staff as of December 2015.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat peoplewith compassion, kindness, dignity and respect.

We rated caring as "good" because:

- All feedback from patients, both verbal and through patient surveys was positive. Patients felt staff took the time to listen to their concerns, provided clear explanations about their care and treatment and on the day of surgery provided care of a high standard. This included treating patients with dignity and respect, and maintaining privacy and confidentiality.
- Patients felt they were treated as individuals and they, and those close to them, were involved in making decisions about their care. Staff considered patients emotional needs, not just their clinical needs. Family members and carers were also offered support.
- All patients would recommend the service to friends and family.

Compassionate care

- All patients we spoke with were very pleased with the quality of care they had received. They told us they were made to feel at ease and had felt comfortable and relaxed prior to having surgery. Staff had spoken to them in a kind manner and treated them with dignity and respect. A patient told us 'the experience had been as good as it could have been'.
- Staff ensured confidentiality and privacy by knocking before entering a patient's room and kept the door closed while providing care.
- Data from the NHS Friends and Family test for July to December 2015 showed for each month the majority of patients were extremely likely to recommend the service to friends and family. The remainder were likely to recommend the service. Response rates over the six months ranged from 50% to 100%, the average was 70%.
- Results from the patient survey for NHS funded day case and in-patients for December 2015 were positive. Patients were asked in more detail about their experience of care, including whether their privacy and dignity was maintained, ease of understanding explanations given by staff and the standard of the accommodation. Comments from patients included 'very happy with every aspect of the hospital and staff' and 'I was impressed with the quality of care'.

Understanding and involvement of patients and those close to them

- Patients and carers told us all staff had given clear explanations, in sufficient detail for each stage of their care and treatment. They were also given written information to support the discussions that had taken place.
- We observed staff introducing themselves prior to explaining any tests or observations the patient needed.
- Patients told us they appreciated the time staff spent with them to answer any concerns they had. They had found it helpful seeing the anaesthetist and consultant prior to having surgery.

Emotional support

- A carer told us they valued the support staff had given them on the day of surgery. Staff had considered their needs and provided meals for them during the day.

- At discharge, patients were given an emergency contact telephone number should they need to speak to a member of staff about any concerns they had. Nursing staff called all patients two days after surgery to see how they were progressing with their recovery and how they were feeling.

Are surgery services responsive?

Good

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

We rated responsive as "good" because:

- The service had strict selection criteria to ensure only patients whom the hospital had the facilities to care for were referred. Patients told us the whole process from booking their initial appointment, to being discharged post-surgery was efficient and well organised. There were minimal waiting times for surgery.
- Staff established if patients had additional needs as part of the pre-operative assessment process to ensure they were supported appropriately during their stay in hospital. Adaptations had been made to rooms to ensure they were accessible for patients with mobility needs or living with dementia. There were systems in place to support patients who were non-English speaking.
- The complaints process was effective and complainants kept informed of the outcome into the investigation of their complaint. Minutes identified learning from complaints and action taken, which was shared with staff at team meetings and senior management discussed at governance meetings.

Service planning and delivery to meet the needs of local people

- Through the 'any qualified provider' contract with the Department of Health, the hospital was a provider of specific NHS procedures as part of the Choose and Book system. This is an e-booking software application for the National Health Service in England. It enables patients needing an outpatient appointment or surgical procedure to choose which hospital their GP refers them to, and to book a convenient date and time for their appointment. Through this initiative, the hospital could provide a selection of NHS services including, but not limited to, knee and hip surgery and hernia repairs.
- The hospital also saw patients who had private healthcare plans. Patients could also opt to pay for their treatment themselves.
- Patients told us that they were able to arrange admissions times in agreement with their consultants, which gave them flexibility. There was one theatre session a week held in the evening, increasing opportunities when patients could choose to have their surgery.

Access and flow

- The hospital had written criteria listing which medical conditions would mean patients could not be admitted to the hospital for surgery. This meant the patient type was carefully managed to ensure that the hospital could meet their needs.All patients completed a pre-admission health questionnaire and all patients considered suitable for surgery were reviewed in the pre-assessment clinic, prior to having surgery.
- Data for January to December 2015 showed the average waiting time from GP referral to admission for all procedures was 22 days (ranging 8 to 27 days).
- Operating sessions were made up of an equal mix of patients who had selected the hospital through Choose and Book and private patients, both as inpatients or day-case procedures. From January to December 2015, approximately 40% of activity was through NHS contracts. There had been 51 NHS-funded inpatients for operations requiring an overnight stay and 450 NHS funded inpatient day-case procedures, compared with 78 self-funded and insured inpatient overnight stays and 610 day-case procedures.
- Patients told us the booking process had been smooth and efficient. They had been sent paperwork in good time and were seen on time when attending for pre-operative appointments.
- The pre-assessment clinics ran daily and worked flexibly in order to meet the needs of the patients.
- Discharges were authorised by the admitting consultant. On occasions, the resident medical officer would act on behalf of the consultant to discharge a

patient following their instructions. This meant patients could be discharged in a timely way. Surgery Good ––– 28 The Foscote Private Hospital Quality Report This is auto-populated when the report is published
- Medical staff had to give six weeks notice of their annual leave so that surgery lists could be planned and to avoid patient cancellations.
- Between January and December 2015, the hospital had cancelled 13 operations on the day of surgery for clinical reasons and cancelled five operations for non-clinical reasons.

Meeting people's individual needs

- Information on patients' additional needs was recorded by nursing staff during the patient's pre-assessment. This included information about any disabilities and social support needed during the patient's stay or once discharged.
- Staff could access an interpreter through the language line facility, this enabled them to support patients for whom English was not their first language. Access to an interpreter was documented on the outpatient booking form for patients requiring admission to hospital. Staff also recorded the need for an interpreter on the consent form.
- All written information, including pre-appointment information, was provided in English. Leaflets did not inform patients how to access the information in other formats, such as large print or braille. However, this information was available in languages other than English on request.
- Patients spoke positively about the choice and quality of the food, it was appropriate for their needs post-surgery.
- Nursing staff discussed patients' dietary requirements as part of their pre-operative assessment and on admission. They passed any specific needs to the catering team so they could source and prepare appropriate food for patients.
- The catering team found it helpful to have patients' dietary information in advance and sought advice from the dietician when planning the menus. We reviewed the menus, they clearly showed patients which meals were vegetarian, high energy or gluten free for example.
- Staff recognised the need for supporting people with complex or additional needs and made adjustments wherever possible. Staff told us that patients living with dementia or who had a learning disability attended the service infrequently but they described how they would support these groups of patients and how they could adapt their approach to provide care, considering the person's additional needs. One of the patient rooms had been redesigned so it provided a more suitable environment for a person living with dementia. Another room had additional space so a family member or carer could stay with the patient.
- On the ward, there were picture and letter cards to help staff communicate with people who had a hearing or sight impairment. Telephones in rooms had large buttons for ease of use for those with restricted vision or poor mobility.
- The layout of the hospital meant all areas were accessible for people in a wheelchair.

Learning from complaints and concerns

- The hospital had an up-to-date complaints policy, with a clear process to follow to investigate, report and learn from a complaint. There were 10 complaints for the whole hospital for the period January 2015 to December 2015, four were clinical and six non-clinical.
- Staff were aware of how to manage complaints and when to escalate them to a senior member of staff. Staff told us they had started receiving feedback on learning from complaints at team meetings. All staff had access to the governance meeting minutes where complaints were discussed.
- In response to the four clinical complaints, investigations had been completed and recommendations made. Recommendations included updating the patient information leaflet for patients having steroid injections and requiring patients to wash with a specialist lotion on the day of surgery to reduce the risk of a surgical site infection. There were no reoccurring themes.

Are surgery services well-led?

Good

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

Surgery

We rated well-led as "good".

During our inspection in August 2015 we found:

There had been some response to the changes which needed to be made, but further work was needed to address the 'custom and practice' culture of the operating department. There was lack of challenge at the clinical governance committee meeting. Polices which were in use had not been formally ratified and adopted and there was no established monitoring of practice against policy to ensure the quality of the service being provided.

During this inspection we found:

Staff were informed about the vision or values for the hospital and were aware of possible development plans for the hospital.

Governance processes in surgery were overall well developed to manage risks and quality. Each department had a risk register. Heads of departments monitored the risks and kept a record of the action taken to reduce the level of risk. They escalated higher rated risks to the newly developed hospital wide risk register, where the hospital's senior management committee reviewed them. Heads of departments shared information about incidents and patient experience through team meetings.

Staff completed internal audits relating to safety and infection control. The service also submitted outcome data to national databases. Systems had been introduced to monitor staff practice against policy to ensure the safety of patients.

Staff in all areas said that their manager was visible and approachable and they spoke highly of their managers. They continually told us that they felt well supported and valued. Staff told us that they enjoyed working for the hospital due to the strong team support from colleagues.

Staff vacancy, turnover and sickness rates were all low in surgery outpatients and diagnostic imaging. Staff felt included in decisions around changes to services in their department and the hospital.

Patients were given opportunities to provide feedback about their experiences of the services provided and the hospital had made changes in response to this feedback. Staff were encouraged to make suggestions on how they could develop their own service or make changes to improve the patient experience.

The hospital had a business plan in place and identified a number of projects to develop and improve the service. •

There were no multidisciplinary team meetings to enable sharing of learning and development of the surgery service.

There was no internal clinical audit or use of outcome data locally to monitor the quality of the surgery service at the hospital.

Vision and strategy for this this core service

The hospital's vision was 'The Foscote Hospital will be the first choice for patients and consultants to have and deliver exceptional sustainable high quality care, and for our staff to work'. The hospital had set aims and objectives to support this vision. Challenges to achieving the aims had been identified. Most staff were aware of the vision or strategy for their department or the hospital.

Governance, risk management and quality measurement for this core service

Events including incidents and complaints were captured in the new electronic events management system. A number of reports could be run from the new system including the number and type of event.

The provider had streamlined a number of committees following a review of the new reporting structure. Terms of reference were in place for each of the main committees clearly defining their roles, responsibilities and membership.

All committees reported to the quality and risk committee chaired by the hospital manager. This committee reported to the senior manager team who in turn reported to the council of management (the trustees). The medical advisory committee (MAC) had input into all three of these meetings.

Senior management had implemented a standardised agenda for the monthly quality and risk committee meetings. Following the head of department meeting there was an expectation that they would cascade information to their teams following the same framework. Heads of department shared this information with their teams through team meetings, via email and at handovers. We reviewed minutes for the quality and risk committee

meetings, which identified how specific action points had been reached. A review of the template used for minutes had led to the development of a new template to capture discussion, decision and action points.

We saw in the minutes from the Medical Advisory Committee (MAC) that decisions to grant or stop practicing privileges had been discussed and appropriate action taken, where the MAC had identified concerns about performance or conduct.

A schedule of audits was in place and clearly laid out in the hospital wide audit calendar. Audit questions for all audits were under review to ensure they applied to the services provided by the hospital. However, there were no clinical audits as part of the surgery service, to monitor the quality and effectiveness of the care and treatment provided to patients.

Theatre staff took ownership of a different theatre audit each month so they gained experience of monitoring best practice over a number of different areas, with the intention to improve the quality of the surgery service overall. Audit results were shared with staff at team meetings.

We reviewed three standard operating procedures (SOP). All were in date, had a version number and review date to ensure staff knew which was the current version to refer to. Staff were required to sign to show they had read any new polices or SOP.

The ward and theatre had a risk register that included all known areas of risk identified in the service. Heads of department kept a record of the action being taken to reduce the level of risk and monitored compliance to any due dates. All risks had a responsible person allocated to them. Members of the quality and risk committee regularly reviewed the risks as part of their meetings and escalated them appropriately. Higher rated risks were added to the newly developed hospital wide risk register where the hospital's senior management committee reviewed them.

A daily 'huddle' took place each morning at 8:45am, attended by the heads of department where they reviewed what was happening that day and any issues identified. Notes were circulated to the rest of the staff.

The hospital had a lone-working policy and department specific procedures to keep staff safe. This included CCTV and an alarm for staff to carry when working by themselves, which sounded in three areas of the hospital in the event of an incident. Alarms were kept on charge when not in use to ensure there were always alarms available for staff to use.

Patients who were seen privately or were self-funded were made aware of the terms and conditions of the services being provided to them when they checked in for their appointments. This information was contained in the registration form.

Leadership of service

Staff felt well supported by their head of department and told us they could raise concerns with them. All heads of department worked clinical shifts so they had an awareness of issues, which may affect members of their team.

Staff spoke highly of the senior management team and appreciated the visits of the Chair of the Trustees. They felt the senior team had been 'very professional and coped well' during the last few months with all the changes made.

There was a clear intention to give heads of departments greater ownership of their department, with a clear framework within which to work, moving away from senior management doing many things for them.

We spoke to two heads of departments who had identified additional training to complete to support them in their leadership role, they planned to discuss this with their manager. Heads of departments felt well supported by the senior team at the hospital.

Culture within the service

Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.

Staff worked well together and felt valued team members. Staff commented how everyone supported each other. This was reflected in low vacancy, sickness and turnover rates in all departments.

Staff were proud to work at the hospital and felt senior management and the trustees were open and transparent with them during the recent periods of change. They told

us the hospital was now a 'different place' since the two previous CQC inspections, it had been a 'wake-up call'. Everyone had worked hard to put in place the changes that were needed.

There were no joint meetings between nursing, theatre and medical staff to enable learning to be shared across different teams. Staff groups met individually.

Public engagement

There were examples of patients being involved in service development. These included patient survey feedback such as the Friends and Family Test and learning from complaints. The hospital also asked patients to complete a more detailed survey about their care at the hospital while an inpatient. Staff indicated in the patient pathway that this survey had been given to the patient. Minutes from the quality and risk meeting (January 2016) showed the hospital planned to produce a shorter version of this survey as response rates had reduced and patients were not completing all the questions. The new survey would align more with areas covered by regulation.

The hospital also monitored and responded to comments left on the NHS Choice website.

Staff engagement

Staff of all grades felt involved in decisions about their department and the hospital as whole.

Staff told us they were kept regularly updated about any changes through meetings and access to minutes from meetings. For example, the hospital management team had arranged staff forum meetings to inform the staff about changes and action following the CQC inspection in July and August 2015.

There were plans to use an online survey to review how staff were feeling in view of the changes that had taken place and to see how they felt the managers had managed the process of change throughout the hospital.

Innovation, improvement and sustainability

The pace of change and improvement over the last six months had been significant. There was evidence that the changes were sustainable due to the new governance structure that the senior management team had introduced. All staff understood the importance of monitoring the quality and safety of the service and raising concerns to ensure safe care and treatment for patients.

Staff were aware of possible development plans for the hospital. These included an extension that might consist of a new endoscopy unit, administrative space and space for minor operations.

The hospital was looking at how to increase the efficiency of the theatre space so more operations were performed, increasing the income the hospital received. They also intended to produce more information on patient outcomes to share with GP's to increase the referral rates and promote the service to GP's over a wider area.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at The Foscote Private Hospital included services from 16 different clinical specialities, including cardiology, gastroenterology, orthopaedics, psychology and urology. A diagnostic imaging service was also available, which provided X-ray and ultrasound scans. There was a separate endoscopy suite and a physiotherapy suite. There was one main waiting area for all clinics.

The main outpatients clinic comprised three consulting rooms which could be used by any speciality. All clinics were consultant-led, with support from a healthcare assistant. The majority of outpatient clinics were held Monday to Friday, with some clinics provided in the evening. In the period July 2015 to December 2015, there were a total of 3,908 planned outpatient appointments, 1,396 new appointments and 2,512 follow-ups. Patients attending outpatients were either NHS-funded, self-funded or used private medical insurance. No children were seen at the hospital but young people aged between 16 and 17 could attend for outpatient appointments as private patients.

The endoscopy suite was one room with an area for procedures and a small area within the room for cleaning and drying of scopes. There were five individual patient rooms in the same corridor as the endoscopy suite, allocated for patients attending for an endoscopy procedure. Between January 2015 to December 2015, a total of 458 endoscopies were performed at the hospital.

The diagnostic imaging department has an X-ray machine and a separate room for ultrasound scans. There was also a mobile X-ray machine that could be used, for example, in theatre.

During our inspection, we visited main outpatients, endoscopy, physiotherapy and the diagnostic imaging department. We spoke with six patients and 18 staff, including nurses, healthcare assistants, medical staff, physiotherapists, radiographers, administrators, receptionists, cleaning and catering staff. We observed care being provided, reviewed five patient records and analysed data provided by the hospital both before and after the inspection.

Outpatients and diagnostic imaging

Summary of findings

Overall, this core service was rated "good". We found outpatient and diagnostic imaging services were "good'' for safe, caring and responsive and well-led. We report on effectiveness for outpatients. However, we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department.

- Staff reported incidents in line with hospital policy and the learning was shared to improve services. Staff understood the principles of openness and transparency that are encompassed by the duty of candour. Staff followed infection control processes. We identified infection control risks in endoscopy, due to the positioning of the decontamination unit. The hospital was aware of this risk and had taken actions to minimise any infection risks. The environment was visibly clean and well maintained, with all clinical areas providing hand-washing facilities and hand sanitiser gels for patients and staff. There were sufficient numbers of staff, but nursing staff in endoscopy raised concerns around the skill mix of staff, in the absence of the lead nurse. Equipment was well maintained and patient records were available for appointments.
- Departments followed national guidelines relating to their service. Patient Reported Outcomes were reported on in the physiotherapy department. The endoscopy unit had started reporting quality indicators as part of the Global Rating Scale, to assess how well they provide a patient-centred service. Staff had received annual appraisals and were able to access relevant training to update their clinical skills specific to their roles. Staff worked effectively within their teams and across the hospital as a whole to support patient care.
- Staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment plan and had been involved in decisions about their care. Patients were encouraged to consider their overall wellbeing as part of their treatment plan.
- There was an interpretation service for people for whom English was not their first language and the hospital was accessible to those with a disability. There was prompt access to appointments after referral, both in the daytime and the evening. Friends and Family Test scores were positive.
- Staff were informed about the vision or values for the hospital and were aware of possible future development plans for the hospital. Governance processes in the outpatients department, endoscopy and diagnostic imaging were overall well developed to manage risks and quality. Staff spoke positively about the leadership locally and the visibility and support of the senior team. There was an open culture and staff felt they could make suggestions to improve services for patients.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

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

We rated safe as "good".

During our inspection in July 2015 we found:

- Staff were reporting incidents but the learning from these incidents was not shared. Staff had limited understanding on Duty of Candour. There was a lack of visible hand sanitiser points for patients to use in the main waiting area. Nursing staffing numbers were appropriate to the outpatient clinics held. Staff were aware of their responsibilities to complete their mandatory training but reported problems accessing computers to complete the e-learning modules.

During this inspection, we found:

- The hospital had introduced a new electronic system for the recording and reporting of events, which included incidents. Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting radiation-related incidents under the Ionising Radiation (Medical Exposure) Regulations (IRMER) and followed procedures to report incidents to the Care Quality Commission.
- All the staff in outpatient clinics and diagnostic services had completed training related to duty of candour regulation. Staff understood the principles of openness and transparency that are encompassed by the duty of candour.
- Staff followed infection control processes. The environment was visibly clean and well maintained, with all clinical areas providing hand-washing facilities and hand sanitiser gels for patients and staff to use.
- Equipment in use was well maintained and had been regularly serviced. Medicines, including controlled drugs, were stored safely and securely in all departments.
- Patient records created by the hospital were available for appointments.
- Staff compliance with mandatory training was generally good. However only 17% of staff across the outpatients department had completed the practical training in basic life support as of December 2015. Staff were appropriately trained, and had a good understanding of safeguarding procedures.
- Nurse staffing levels were appropriate for the outpatient clinics held. There were 47 consultants who were granted practising privileges to work with the hospital. There was a resident medical officer present on site at all times. Staff had also received training in escalating concerns and referring unwell patients to the local NHS hospital. However:
- A yearly decontamination audit carried out in the endoscopy unit (January 2016) had rated the overall compliance of the unit as 'amber' (medium risk) against the various decontamination procedure outcomes. The provider was aware there was an infection control risks in endoscopy, due to the positioning of the decontamination unit, and had taken actions to minimise any infection risks.

Incidents

- The hospital had recently introduced a new electronic system for the recording and reporting of events, which included incidents. The event system also captured information on the number of complaints, safeguarding referrals, never events, serious incidents and accidents. Each event had a unique identifier number. Any information relating to the event was saved in a folder named using this number for ease of cross-referencing. This new system had replaced the clinical or non-clinical incident log book previously used by the staff. Staff we spoke with knew how to recognise and report incidents on the electronic recording system. They had received training to use the new system and stated they felt confident and were encouraged to report incidents.
- There were 33 reported events across the hospital between October 2015 and December 2015. Three of these were reported to have occurred within endoscopy unit. These had all been reported on the new events system. The review of these events demonstrated that detailed investigations had taken place and learning was shared with the staff. The hospital planned to revise the events management report to show the type of events which occurred in each area.
- Heads of departments told us that incidents would be discussed at the monthly quality and risk meeting and

they would verbally share learning with their staff at the bimonthly team meeting. Staff confirmed that feedback on the incidents was disseminated during team meetings, to share learning and improve patient outcomes. Minutes of quality and risk meetings confirmed the themes of incidents were discussed and fed back to staff.

- All staff were aware that they could access minutes from the quality and risk meetings. These were kept in the staff room and on the hospital shared drive computer access system which all staff had access to.
- In the diagnostic imaging department there had been no incidents of exposure of much greater than intended in the last year. It is a requirement of the legislation that if during an X-ray a patient receives a higher dose of radiation than required, this is investigated and reported to the appropriate authority. Staff were aware of their responsibilities to report radiation-related incidents and when to report to the Health and Safety Executive under the Ionising Radiation Regulations 1999 or to the Care Quality Commission under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person.
- All the staff in outpatient clinics and diagnostic and imaging services had completed training related to duty of candour. The hospital had a policy which outlined the process and responsibility of staff whilst implementing the duty of candour regulation.
- All staff who we spoke with understood the principles of openness and transparency that are encompassed by the duty of candour. Staff were aware of the importance of investigating incidents and potential mistakes. They were aware that the duty of candour included making an offer of a meeting with the patient/family and sharing the findings of investigations with them as a legal requirement.

Cleanliness, infection control and hygiene

- All departments, consultation rooms and the main waiting area were visibly clean and tidy.
- In all areas, we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were adhering with the bare below the elbow policy to enable good hand washing and reduce the risk of infection. Staff had access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. Staff washed or applied hand sanitiser gel to their hands between contact with patients.
- Hand sanitiser gel was available in the main waiting room and all consultation rooms, encouraging patients and visitors to maintain good hand hygiene to prevent the spread of infection.
- The outpatients department and endoscopy unit demonstrated 100% compliance with hand hygiene audits between September 2015 to December 2015.
- The hospital had reported one incidence of hospital acquired Methicillin Resistant Staphylococcus Aureus (MRSA) and no incidences of Clostridium difficile in the reporting period January 2015 to December 2015. The MRSA case had been investigated and changes made to practice. The results of MRSA audits were displayed in the waiting areas.
- There was a cleaning matrix in use in each department, which was completed and signed by staff for each task they completed. The matrix indicated the frequency at which a task should be performed. All records we checked were signed and up to date.
- An external annual review of decontamination facilities was carried out on the endoscopy unit (January 2016). This review rated the overall compliance of the unit across the various outcomes of decontamination procedures as 'amber' (medium risk). Recommendations drawn from this audit were mainly about the need for refresher training for the lead nurse on the Automated Endoscope Reprocessor (AER) system. The lead nurse told us that they had booked themselves onto the next available AER refresher training course.
- British Society of Gastroenterology's guidance for decontamination of equipment for gastrointestinal endoscopy (June 2014) states that, decontamination of endoscopes should be undertaken by trained staff in dedicated rooms. There should be one way flow of endoscopes between dirty and clean areas to prevent cross contamination. Best practice is that there should be physical separation of dirty and clean areas, each with their own staff.
- One of the access doors to the decontamination unit for scopes in the endoscopy unit was blocked due to space restrictions within the unit. This prevented the physical

separation of clean and dirty scopes. The hospital was aware of this risk and had taken actions to minimise any infection risks. For example, there was a clear demarcation line marked in the endoscopy room, which separated the area used for loading and unloading clean and dirty scopes in the decontamination room. Only one scope was loaded and unloaded at a time to minimise any infection risk. This was not identified as a risk in the external annual review undertaken for flexible endoscope decontamination facilities (January 2016).

- Infection control training was mandatory for all staff. As of December 2015, 100% of staff across endoscopy, outpatient and imaging departments had completed the infection control training.
- In the radiology department, the ultrasound probe was wiped between patients and sterile gel was used to prevent the spread of infection between patients.
- Staff said they would encourage patients to cancel their appointment if they contacted the department to say they were unwell. Otherwise, they would follow the guidance from their training, assessing the patients' medical need on a case by case basis. Staff ensured they wiped equipment and isolated patients where possible.
- The hospital cleaning team were reported as being very responsive and would come promptly should an additional clean need to be completed. Staff told us an external company performed a deep clean annually or more frequently if required.

Environment and equipment

- All patient care equipment we checked was clean and ready for use and had up-to-date service records. This equipment had been routinely checked for safety and was clearly labelled stating the date when the next service was due. The equipment was also labelled to indicate that portable appliance testing had been carried out to ensure it was fit for use. Reception staff held a list of all the companies providing maintenance and servicing of equipment so they could be contacted promptly if needed.
- There was a central contract for the servicing of most equipment and the servicing company updated the log detailing when the equipment had been serviced and when it was next due a service.
- The endoscopy unit undertook the Association for Perioperative Practice peer review audit in September 2015 in line with the Joint Advisory Group (JAG) Endoscopy, national endoscopy program guidance. The audit reviewed several quality and safety measures in endoscopy in line with national guidance. As a result of this audit, a few urgent actions were recommended in relation to environment, design and layout within the endoscopy unit. The provider had created an action plan following these recommendations and the urgent actions were being implemented into practice. For example, new double sinks were installed in the decontamination area used for washing and rinsing of the endoscopes and a new air ventilation system was installed.
- Staff told us they had no concerns regarding availability or access to equipment. A drying cabinet had recently been purchased for the endoscopy department. Staff were receiving training on how to use this as a part of their competency assessment.
- There were resuscitation trolleys on each floor, which were secured with a numbered tag, with an additional 'grab bag' in reception. Staff checked the resuscitation equipment every day to ensure that the correct equipment was available and fit to use. Single-use items were sealed and in date, and emergency equipment had been serviced.
- The housekeeping team were responsible for the waste disposal. There was clear labelling of all clinical waste bins to ensure rubbish was disposed of appropriately.
- Risk assessments had been undertaken in physiotherapy in relation to the safe use of equipment, pushing of wheelchairs and disposal of clinical waste. The hospital's environment workplace audits for outpatients department (January 2015 and June 2015) showed 100% compliance.
- The hospital provided personal protective equipment (PPE) for staff, patients and carers in the diagnostic imaging department to limit exposure to radiation. Staff told us items were checked for damage and taken out of use if a fault was found. The PPE was used in theatres when a patient had an X-ray performed using the mobile X-ray machine.

Medicines

- The hospital had an established system for the management of medicines to ensure they were safe to use. This included clear monitoring of stock levels, stock rotation and the checking of expiry dates of medicines.
- Medicines, including controlled drugs, were stored safely and securely in all departments. All medicine cupboards were kept locked.

- Two people, in line with hospital policy, had signed all entries in the controlled drugs book for the endoscopy unit (October 2015 – December 2015).
- The monthly medicine management audit conducted for endoscopy unit showed 100% compliance across all the outcomes (November 2015 - December 2015).
- Patients' medication charts clearly identified any known allergies to reduce the risk of them being given inappropriate medication.
- In all departments, the consultant or resident medical officer (RMO) was responsible for prescribing medications to patients and documenting this in the patient's record.
- Prescription forms were stored securely on the ward and a consultant in outpatients could request a form if needed. FP10 prescription pads or private controlled drug prescription forms were not stored on the premises.
- All patients we spoke with were clear on their overall treatment plan, including when to take any prescribed medicines.

Records

- We reviewed five sets of patient records in physiotherapy and endoscopy unit, all of which were complete, with up-to-date assessments, care plans and observation charts.
- The patient records were comprehensive, including clinical notes, admission records, pre procedure checklist, procedure records, discharge information, and discharge checklist.
- Records for the patients were created and stored securely on site at the hospital or at an offsite secure facility. Records were available on appointment. Staff could request either the original records or electronic copy of records stored at the offsite secure facility. The hospital confirmed that these notes were made available within four hours of request.
- Notes for the current outpatient clinics were stored in a lockable cupboard in reception and placed in the consulting room before the clinic started, which ensured patients' records were kept confidential.
- The hospital had a system to ensure that any information held electronically was secure; including password protected access and information back up in case of system failure.
- Consultants owned a responsibility for private patient notes. Their secretary was responsible for providing the notes needed for each clinic. Each consultant was required by the hospital to register annually with the Information Commissioner's Office (ICO), a publicly accessible online register. The ICO requires consultants to handle and store patient-identifiable information in a safe way.
- The consultant was required to provide the hospital with a minimum set of data for the hospital file, including a medical history for the patient. The hospital had recently introduced a pre-medical questionnaire for patients to be completed at their first outpatient appointment or before an endoscopy procedure. This questionnaire was sent to the patient before their first appointment along with a pre-paid envelope. Staff told us that this information, once received, was filed in patient's folder.
- The outpatient staff prepared the medical records for clinics and checked that a record was available for each patient booked for the clinic. They also ensured that all of the relevant paperwork was available for the consultation. If a patient's medical records were not available for a certain reason, staff would make the decision to either cancel or continue with the appointment after liaising with the consultant. Staff told us this would be based upon the individual patient and the amount of information available. However, the hospital confirmed that this occurrence was rare and had not occurred in the last five years. For patients being admitted for a procedure, a medical file was created, which was stored on site at the hospital at all times. This ensured that medical records were available to other staff who may be required to provide care or treatment to the patient.
- The physiotherapy department took part in the notes audit for patients seen on the ward. Feedback from this was provided verbally and was accessible on the hospital shared drive. Physiotherapy staff also undertook peer review of records, in line with guidance from the Chartered Society of Physiotherapy Quality Assurance Audit tool. The results from these audits were positive.
- The endoscopy unit performed a monthly medical records audit. The audit performed in December 2015 showed that the compliance of the unit was 94% against various audit outcomes. The audit had

identified that staff needed to ensure that all record entries were dated, signed and initialled including staff designation. During the endoscopy session we observed, all notes were filled in correctly and signed.
- The most recent annual radiation protection adviser report (May 2015) recorded that the diagnostic imaging department had registered their work with ionising radiations with the Health and Safety Executive.

Safeguarding

- There was a safeguarding children and adults at risk policy. The hospital did not provide services for children under 16, however, it did see children aged 16-18 in outpatients. It was important staff were able to recognise a child at risk, and know how to raise concerns, should a child attend with a family member or carer during an appointment or visit. The hospital manager was the named person for safeguarding. The policy described what would place an adult or child at risk and the types of abuse. There was also a flow chart indicating the action staff should take if concerns were identified.
- Safeguarding training was provided through an e-learning package. It was mandatory for all staff as part of the induction process and would then be updated annually.
- Staff told us they had received training in safeguarding adults and children at risk and were aware of the hospital's safeguarding policy. Safeguarding concerns were reported as incidents; staff were not aware of any recent safeguarding incidents.
- The percentages of staff who had completed the safeguarding level 2 training varied between 84% to 91% across outpatients and diagnostic imaging services.

Mandatory training

- The mandatory training package contained a mix of e-learning and face-to-face training, including basic life support, hand hygiene, conflict resolution, and moving and handling. There was a list identifying which mandatory training staff needed to complete dependent on their role.
- The data provided by the hospital showed compliance with mandatory training varied across different services. The percentages of staff completing their mandatory training varied between 17 % to 100%, with most of the staff achieving compliance between 90% to 100% as of December 2015. However, only 17% of staff across the outpatients department were up to date with the practical training in basic life support as of December 2015. The provider was unable to provide a target for expected training compliance.

Assessing and responding to patient risk

- All staff understood the procedure to follow should a patient collapse or become acutely unwell in the outpatient, endoscopy or diagnostic imaging departments. The hospital had a deteriorating patient pathway, which involved the RMO stabilising the patient and then arranging transfer to an acute NHS unit. Staff, including the RMO, were aware of the correct pathway to follow.
- There was always a RMO on duty, who provided medical support to staff in all departments as required. Staff said the RMO responded quickly when called. Departments either had a call bell or blew a whistle to draw staff attention to a situation where they needed support in an emergency.
- The RMO held a current advanced life support qualification to enable them to take a lead role if a patient suffered a cardio-pulmonary incident. They would support a patient through an emergency until the emergency services arrived.
- There were protocols for making urgent referrals to specialist NHS services when required and staff were aware of them.
- The diagnostic imaging service had a strong working relationship with the radiation protection adviser , who they contacted as required. The lead for the diagnostic imaging service was also the radiation protection supervisor for the department, who took responsibility for ensuring the department met all the standards required under Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) to minimise exposure risks to patients and staff.
- The radiation protection supervisor at the hospital kept a list of medical and other clinical staff who could make referrals. Each referral was individually justified by a radiologist.
- There were signs to advise patients and staff about rooms where radiation exposure took place. There was a notice in the imaging room and the patient changing room advising women to tell staff if they were, or thought they might be, pregnant. This sign was in multiple languages and picture form. Patients were also

asked as part of the radiological checklist if there was a possibility they might be pregnant. Pregnancy testing kits were stored on the ward, for use should a concern arise.

Nursing, physiotherapy, imaging staffing

- Nursing staff we spoke with told us there were appropriate numbers of staff to cover clinics, this was confirmed during our observations in outpatients. Nursing cover was planned around consultant clinics or endoscopy sessions. There were sufficient numbers of staff in physiotherapy and radiography, to enable them to provide a safe service, to cover both the outpatient and inpatient aspects of their services.
- The hospital's physiotherapy and diagnostic imaging services both used bank staff to cover annual leave, sickness or additional clinics. There was no use of agency staff in any of the departments we inspected.
- One health care assistant was employed to work in outpatients. There were arrangements to provide cover when they were on training or on leave.
- Physiotherapy staff had a handover with the lead nurse on the ward each day, so they were kept updated on all patients admitted to the hospital.

Medical staffing

- There were 47 consultants granted practising privileges to work with the hospital. The term 'practising privileges'' refers to medical practitioners being granted the right to practice in a hospital.
- Practising privileges were granted through an application and review process and had to be agreed by the medical advisory committee. This was supported by minutes of the medical advisory committee meetings. These privileges were reviewed annually. To continue to use this privilege, consultants were required to provide evidence of current registration with the General Medical Council, current professional indemnity insurance, an appraisal confirming their normal practice, Hepatitis B status, and registration with the Information Commissioner's Office. Consultants were required to sign a contract indicating they would adhere to the hospitals policies and procedures.
- Administration staff at the hospital did not manage the consultants' diaries; their private secretaries confirmed clinic and surgery session dates with the hospital.
- There was an RMO present on site at all times. For endoscopy patients, they spoke to the relevant consultant for the patient if they needed more senior medical advice on how to care for a patient.
- It was the responsibility of the consultant to identify another named consultant to cover during a period of leave.

Major incident awareness and training

- The hospital had a business continuity plan that included the process for staff to follow in the event of a major incident, such as a fire or flood. This were supported by 'Action cards' which were quick reference guides for staff, containing key action points and useful contact names and phone numbers.
- Staff were aware of the emergency procedures for the hospital and their role in the event of a fire or significant incident. Staff told us they had taken part in a fire drill this year.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department.

During our inspection in July 2015 we found:

- The nursing staff in the endoscopy department had not received specific training for the role of assistant, which they undertook during an endoscopy. Departments followed national guidelines relating to their service. There was no audit undertaken by the hospital of clinical performance in the endoscopy department.

During this inspection, we found:

Outpatients and diagnostic imaging

- Departments followed national guidelines relating to their service. The endoscopy unit had recently started collecting information for auditing purposes to understand the effectiveness of the endoscopy service. This audit was ongoing at the time of our inspection.
- Staff monitored pain scores for patients who had undergone a procedure in endoscopy. Patients reported that their pain was assessed and responded to in a timely manner. Pain relief medication was prescribed either by the resident medical officer (RMO) or the consultant caring for the patient.
- Patient Reported Outcome Measures (PROM) were measured in physiotherapy to monitor the quality of the service and patient improvements in response to treatment. The Endoscopy unit had started reporting quality indicators as part of the Global Rating Scale (GRS), to assess how well they provide a patient-centred service.
- Staff in the outpatients and diagnostic imaging departments had appropriate registration for their role. Most staff had received an annual appraisal and felt able to access relevant training to update their clinical skills specific to their roles.
- There was effective multidisciplinary working across all departments to keep patient appointments to a minimum and enable patients to receive a care package developed around their needs.
- Outpatient clinics were held during the week, with a number of evening clinics. Out-of-hours cover was provided in diagnostic imaging and inpatients received physiotherapy treatment at weekends.
- All staff raised concerns around the time taken for test and scan results to be reported on. These services were outsourced to another provider. An audit of response times had been completed and the hospital was considering the most appropriate action to take.
- Staff obtained and recorded consent appropriately.

Evidence-based care and treatment

- Staff in the endoscopy unit followed British Society of Gastroenterology (BSG) guidance. Consultants recorded completion rates and polyp detection rates to enable them to audit their own individual practice and used this information as part of their substantive post appraisal. The endoscopy unit had recently started collecting this information for auditing purposes to understand the effectiveness of the endoscopy service. This audit was ongoing at the time of our inspection.
- In diagnostic imaging, the radiography service was provided in line with the Ionising Radiation Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This included maintaining records of equipment servicing, having access to qualified specialists and complying with local policies and procedures for using equipment.
- Local diagnostic reference levels (DRLs) were in use in the imaging department. DRLs ensure a patient does not receive an unnecessarily high dose of radiation. The department had recently audited its diagnostic reference levels (DRLs) against the National DRLs 2012. In response to this, new guidance had been introduced to change the exposure setting on the X-ray unit and protect patients.
- Staff could access guidance such as the National Institute for Health and Care Excellence (NICE) guidelines on the hospital computer system. The hospital received email alerts when NICE guidance had been updated, so staff could review and amend policies and practices as needed.

Nutrition and hydration

- Patients were usually offered a light snack following their endoscopy procedure. If a patient was given a sedative for endoscopy, staff explained to the patient about the duration of time they should not be eating or drinking following the administration of a sedative. This was also recorded in the patient records.

Pain relief

- Patients reported that their pain was assessed and responded to in a timely manner.
- Staff monitored pain scores for patients who had undergone a procedure in endoscopy. We reviewed three sets of records for patients who had undergone endoscopy procedure and pain assessments were included in the documentation.
- Physiotherapists offered complimentary pain relief therapies through the use of acupuncture.

Patient outcomes

- Endoscopy units are encouraged to report on a number of quality indicators as part of the Global Rating Scale (GRS), to enable them to assess how well they provide a patient-centred service and to enable any improvements to the patient experience and quality of the service. Following the previous inspection in August

2015, the endoscopy unit had started collecting GRS data regarding the quality indicators such as patient comfort scores, sedation concerns, completion rate and polyp detection rate. This audit was ongoing at the time of our inspection.

- The physiotherapy service reported on the patient reported outcome measures programme (PROMs) through the use of the national quality of life questionnaire (EQ-5D-5L). All patients completed this at the start and end of their treatment. The figures obtained were reviewed as part the departmental review of service. The data provided by the hospital demonstrated that the improvement in patients' condition post physiotherapy treatment ranged between 86% to 100% (January 2015 - December 2015).Physiotherapy staff had taken further actions such as referral to a consultant and further investigations to facilitate the improvement in patients' conditions where improvement was below 100%.
- In diagnostic imaging, there was evidence of participation in local audits, radiology referral forms audit, patient dosage audit and infection control audits. The patient dosage audit for July 2015 had resulted in a change to the exposure setting on the X-Ray unit to reduce the radiation dose to the patient.
- The hospital had also recently joined the Private Health Information Network (PHIN). PHIN provide information for the public on 11 key performance measures, so a patient can make an informed choice where to have their care and treatment for providers offering privately funded healthcare. No data was yet available.

Competent staff

- The nursing staff working in endoscopy had recently started using the 'Gastrointestinal Endoscopy for Nurses' (GIN) competency framework. The GIN programme is supported by the Joint Advisory Group (JAG) endoscopy programme. It aims to update the nursing staff on service developments in endoscopy and ensures a structured approach to training, assessment and appraisal. We reviewed the GIN competencies of two endoscopy nursing staff which demonstrated clearly set objectives, self-assessments and training needs analysis. The endoscopy nurses had enrolled themselves on a number of training days provided by the endoscope manufacturing companies. The lead nurse had also enrolled herself on the GIN training day.
- Nursing staff in endoscopy told us, in the absence of the lead nurse they were anxious about taking the lead role, as they had not completed any formal endoscopy nurse training. The hospital advised that sessions were cancelled in the absence of the lead nurse and the nurses were working on GIN competencies, which would increase their knowledge base and make them competent.
- All staff in outpatients and diagnostic imaging department had received an appraisal during the last year.
- Staff in the physiotherapy department completed a peer-to-peer review of patient notes as part of their continuing professional development.
- Clinical head of departments checked their staff's professional registration every six months to verify that staff could continue to practice, including staff in the diagnostic and imaging service who administered radiation.
- As part of the process of granting privileges to consultants, evidence was reviewed regarding the consultant's competency and their current professional registration. We reviewed the minutes from the Medical Advisory Committee (MAC), which showed that decisions to grant or stop practicing privileges had been discussed, and appropriate action taken, where the MAC had identified concerns about performance or conduct.
- The RMO induction included a week shadowing the current RMO so they had opportunity to familiarise themselves with the hospital's procedures.

Multidisciplinary working

- There was evidence of multidisciplinary working in outpatients to enable efficient delivery of care to patients and limit the number of times they needed to attend. Patients requiring a blood test or scan were seen on the same day as their outpatient appointment where possible.
- From the staff we spoke with, there was evidence of strong working relationships between different staff groups.
- Nursing staff and health care assistants across the outpatients department, radiology and endoscopy unit told us that they had good working relationships with the consultants from each speciality. They felt that on-going communication with medical colleagues improved a patient's experience within the department.

Outpatients and diagnostic imaging

- Staff in the physiotherapy department had developed joint treatment protocols with the consultants for certain patient groups, which had been signed by relevant staff and were in date. Examples seen were for knee arthroscopy and hip and knee surgery.
- Nursing staff had been competency assessed and signed off by a physiotherapist, so they could support patients to practise using stairs, fit a specialist cuff after knee surgery and supply a walking aid. This supported patients with their recovery and treatment.
- In diagnostic imaging, radiography staff obtained previous scan results for patients and attempted to avoid unnecessary scans where possible.

Seven-day services

- Outpatient clinics were generally held Monday to Friday, with some appointments offered in the evening. The diagnostic imaging department provided routine appointments during outpatients opening and on-call cover to the wards all day, every day, when the hospital was open.

Access to information

- All clinical staff we spoke with raised concerns around the time taken for test results, such as pathology, histology and CT and MRI scans, to be reported on and sent back to the hospital. These services were outsourced to another provider. Staff regularly reported having to chase up test results and arrange for them to be faxed over so they were available for patients' appointments. This concern had been reported as a risk on the outpatient departmental risk register, as this had resulted in medical staff being unable to discuss the test results with patients at their outpatients appointment, which could result in a delay of treatment.
- In response to this concern, the hospital had conducted an audit by recording data on response times for pathology, microbiology and histology test results over a four-week period in September 2015. The audit showed that for outpatients, 13% of results (four out of 30) took 10 days or more to be returned to the hospital. An action plan in response to the outcomes of the audit was being developed at the time of our inspection.
- Consultants and staff did not have access to the external provider's electronic test reporting system or access to the picture archiving and communication system (PACS) for viewing X-ray and scan results. The radiology images that came from another site were burnt onto encrypted CDs. Consultants and radiology staff were able to view these images using the computers in the consulting rooms. Radiology and senior management staff told us that there were plans to introduce PACS in the hospital in the next few months. Consultants told us they also accessed the results at the local NHS hospital where they held their substantive posts.
- Letters were sent to the patient's GP after each consultant visit and at discharge from other services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had an understanding around consent procedures and how patients should be supported in every day practice about their treatment before giving consent. There was good evidence of consent being sought and comprehensive consent documentation being used in outpatient department and endoscopy.
- Staff completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training as part of their safeguarding vulnerable adults training. Staff we spoke with had an understanding of how this applied to patient consent but told us they had never had to implement the training.

Are outpatient and diagnostic imaging services caring?

Good

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

We rated caring as "good".

- All feedback from patients, both verbal and through patient surveys was positive. Patients were treated with dignity and respect and confidentiality was maintained at all times during consultations.
- Chaperone signs were displayed in the main waiting area and in all clinical area. Staff were observed asking patients respectfully if they required a chaperone during their consultation.

Outpatients and diagnostic imaging

- Patients and carers told us that they were included in the decision making regarding their care and treatment. Staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.
- Patients were encouraged to take an active role in their care to maintain their long-term health and wellbeing and to encourage their independence.

Compassionate care

- Feedback from patients and their relatives was consistently positive about the way staff treated them. Patients told us “the staff are caring, friendly and excellent". They commended staff for the pleasant manner in which they spoke to them and the way in which their privacy and dignity was always maintained at appointments.
- We observed positive interactions between nurses, radiographers, medical staff, reception staff and their patients. All staff clearly enabled strong, supportive relationships with patients and their relatives. Staff knocked on consultation room doors and waited for a response before entering. A number of patients specifically commented on staff ensuring the door was closed during their consultation to ensure confidentiality.
- We observed staff introduce themselves and listen to the patient’s concerns before starting the consultation or procedure.
- The layout of the main waiting room meant that conversations between patients and the reception staff could at times be overheard but we observed that reception staff spoke to patients discreetly in an effort to maintain confidentiality.
- Chaperone signs were displayed in the main waiting area and all clinical areas. Staff were observed asking patients if they required a chaperone during consultations.
- In the endoscopy unit, due consideration was given to the patient’s gender and whether it would be more appropriate for a female or male nurse to support the consultant and the patient during the procedure.
- The results of the NHS Friends and Family test demonstrated that 51 out of 53 patients would be extremely likely to recommend the outpatients and diagnostic imaging department (July 2015 to December 2015).The remainder were likely to recommend.

Understanding and involvement of patients and those close to them

- All the patients we spoke with felt well informed and involved in the decision making regarding their care, proposed treatment plan and intended benefits, as well as the possible risks.
- Staff spent time with patients and their families or carers discussing concerns with them and allowing time for them to ask questions.
- Patients knew how and who to contact if they had concerns after their appointment.
- Patients were aware of how they would receive their next appointment date.

Emotional support

- Staff demonstrated a real understanding of supporting patients who were distressed or in physical discomfort and took time to provide the additional care that these patients required. We observed examples of this, especially for patients undergoing endoscopy procedures.
- Staff also called patients two days after their procedure to discuss how the patient was feeling and how their recovery was progressing. This gave patients a chance to seek support if needed. Patients we spoke with gave positive feedback about this process and found it reassuring.
- If a patient was found to have cancer after an endoscopy, the consultant spoke to the patient in private and the patient was referred to the appropriate NHS service for treatment and support from a cancer nurse specialist.

Are outpatient and diagnostic imaging services responsive?

Good

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

We rated responsive as “good”.

- Services were planned and delivered in a way, which met the needs of the population the hospital served. Referrals were accepted for NHS and other funded

patients. There were no concerns about waiting times for NHS or private patient appointments. Patients reported clinics generally ran to time. Delays and cancellations were kept to a minimum.

- Interpretation services were available. Staff reported the language line facility worked well and enabled them to support patients for whom English was not there first language at outpatient appointments. Patients were provided with written information about their diagnosis or planned procedure. Leaflets were in English however, information was available in other languages on request. The hospital was accessible for patients in a wheelchair.
- There were feedback forms for patients to use to provide compliments and complaints. The complaints process for patients was displayed in a visible position in the main waiting room. There were 10 complaints for the whole hospital for the period January 2015 to December 2015. Minutes identified learning from complaints and action taken, which was shared with staff at team meetings and senior management discussed at governance meetings.

Service planning and delivery to meet the needs of local people

- Through the 'any qualified provider' (AQWP) contract with the Department of Health, the hospital was a provider of specific NHS procedures as part of the Choose and Book system. This is an e-booking software application for the National Health Service in England. It enables patients who need an outpatient appointment or surgical procedure to choose which hospital their general practitioner (GP) refers them to, and to book a convenient date and time for their initial outpatient appointment.
- The 'AQP contract enabled GPs to refer NHS patients for an appointment and treatment at the hospital for four of the clinical specialities offered at the hospital. There were set medical exclusion criteria to ensure that the hospital provided care only for patients for whom it had suitable facilities to support them and keep them safe.
- The hospital was registered with a number of insurance companies providing access for patients with private healthcare. Patients could also opt to pay for their treatment themselves.
- The main waiting area was large and well lit, with magazines, a coffee machine and water fountain provided for patients and visitors. Reception and physiotherapy staff used screen protectors to ensure patients' personal details were kept confidential and could not be seen by other staff or patients.
- Patients received suitable information before their appointment. Patients attending for an endoscopy were sent clear information about the procedure, fasting requirements and a pre-admission questionnaire.
- The hospital held outpatient clinics Monday to Friday, with some evening clinics.
- The physiotherapy service offered Pilates classes and Well Women clinics to encourage people to maintain their health.

Access and flow

- Data from January-December 2015 showed the average waiting time from referral to treatment was 22 days (range 8 to 27 days).
- Either the consultant's secretary or the hospital booking co-ordinator sent the appointment information to the patient. This limited the patient being able to choose their appointment time and date. Follow-up appointments were also arranged in the same way, except for physiotherapy, where patients could book an appointment as they left the hospital.
- Patients told us they were usually seen on time for their appointment. Staff would personally speak to the patients to keep them informed about any delays to their appointment.
- Patients had blood taken for testing on the same day as their clinic appointment where possible. Ultrasound appointments had to be booked. Computerised tomography and magnetic resonance imaging scans were arranged with the provider for this service.
- Data provided by the hospital demonstrated that for the period July 2015 to December 2015, a total of 4423 appointments were attended, 784 appointments were cancelled and 202 patients did not attend. The percentage cancelled for NHS patients was 19% and for other funded patients was 13%. There was no significant difference by patient group.

Meeting people's individual needs

- There was adequate seating in outpatients and diagnostic imaging for patients to wait for their appointments, X-rays and scans.

Outpatients and diagnostic imaging

- The waiting areas, consulting and imaging rooms were all wheelchair accessible. There was lift access to all floors in the hospital and an accessible toilet in the main waiting area.
- In the main waiting area, there was a small sign in multiple languages advising patients to indicate if they needed an interpreter. However, staff reported the language line facility worked well and enabled them to support patients for whom English was not their first language at outpatient appointments. Access to an interpreter was documented on the outpatient booking form for patients requiring admission to hospital.
- All written information, including pre-appointment information, was provided in English. Leaflets did not include information on how to access the information in other formats. However, this information was available in languages other than English on request.
- Staff posted information leaflets and written information to patients undergoing an endoscopy to explain the procedure, preparation required for undergoing the procedure and treatment plan. Staff from the endoscopy service called patients the day before the procedure to go through the bowel preparation requirement, to explain about sedatives and the procedure itself.
- Patients attending for outpatient appointments did not routinely have meals at the hospital but patient dietary needs or allergies were recorded as part of the pre-assessment process for patients having an endoscopy procedure. This was checked again when the patient was admitted.
- Staff recognised the need for supporting people with complex or additional needs and made adjustments wherever possible. Staff told us that patients living with dementia or whom had a learning disability attended the outpatient services infrequently but they described how they would support these groups of patients and how they could adapt their approach to provide care, taking into consideration the person's additional needs.
- The physiotherapy service had developed detailed booklets for patients undergoing knee or hip replacement surgery, which involved the patient right from the start of their care pathway. This was to try to promote enhanced and quicker recovery after surgery. There was a space at the back of the booklet for patients to write down questions they might want to ask at future appointments.
- The endoscopy service provided patients with written information, which included information about common gastric disorders; lifestyle changes that patients could make to improve their long-term health and wellbeing after their planned treatment.

Learning from complaints and concerns

- The hospital had an up-to-date complaints policy, with a clear process to follow to investigate report and learn from a complaint. There were ten complaints for the whole hospital for the period January 2015 to December 2015.
- There was information available to patients making a complaint in a visible position in the main waiting room.
- Staff were aware of how to manage complaints and when to escalate them to a senior member of staff. Staff told us they had started receiving feedback on learning from complaints at team meetings. All staff had access to the governance meeting minutes where complaints were discussed.
- In response to five complaints received which related to patients' medical insurance, staff were encouraged to advise patients to check with their insurance company prior to any investigation, to ensure suitable medical cover was available. Information to patients to check funding for investigations and procedures was advertised throughout outpatient reception and in the consultation rooms.

Are outpatient and diagnostic imaging services well-led?

Good

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

We rated well-led as ''good".

During our inspection in August 2015 we found:

- Governance systems were not used effectively in all departments for assurance on the quality of the service. Health and safety risk registers correlated with concerns raised by staff, however, there were no other

department risk registers or hospital risk register relating to the running of the hospital. Staff were not informed about the vision or values for the hospital but felt that the transition to an independent hospital had been well managed.

During this inspection we found:

- Staff were informed about the vision or values for the hospital and were aware of possible development plans for the hospital.
- Governance processes in the outpatients department, endoscopy and diagnostic imaging were overall, well developed to manage risks and quality. Each department had a risk register that included all known areas of risk identified in the service. The higher risks were escalated to the newly developed hospital-wide risk register where they were reviewed by the hospital's senior management committee. Information about incidents and patient experience was shared.
- Staff in all areas said that their manager was visible and approachable and staff spoke highly of their managers. They continually told us that they felt well supported and valued. Staff told us that they enjoyed working for the hospital due to the strong team support from colleagues.
- Staff vacancy, turnover and sickness rates were all low in outpatients and diagnostic imaging. Staff felt included in decisions around changes to services in their department and the hospital.
- Patients were given opportunities to provide feedback about their experiences of the service.
- Staff were encouraged to make suggestions on how they could develop their own service or make changes to improve the patient experience.

Vision and strategy for this this core service

- The hospital's vision was 'The Foscote Hospital will be the first choice for patients and consultants to have and deliver exceptional sustainable high quality care and for our staff to work'. The hospital had set aims and objectives to support this vision. Challenges to achieving the aims had been identified. Most staff were aware of the vision or strategy for the hospital.
- The endoscopy service was considering requesting a pre-inspection Joint Advisory Group on GI Endoscopy (JAG) visit to identify changes needed to the service to enable it to obtain JAG accreditation and enhance its reputation.

Governance, risk management and quality measurement for this core service

- Events including incidents and complaints were captured in the new electronic events management system. A number of reports could be run from the new system including the number and type of events.
- The provider had streamlined a number of committees following a review of the new reporting structure. Terms of reference were in place for each of the main committees clearly defining their roles, responsibilities and membership.
- All committees reported to the Quality and Risk committee chaired by the hospital manager. This committee reported to the senior manager team who in turn reported to the council of management (the trustees).
- Senior management had implemented a standardised agenda for the monthly Quality and Risk committee meetings. Following the head of department meeting there was an expectation that they would cascade information to their teams following the same framework. Heads of department shared this information with their teams through team meetings, via email and at handovers. We reviewed minutes for the Quality and Risk committee meetings. There were detailed minutes to identify how specific action points had been reached. A review of the template used for minutes had led to the development of a new template to capture discussion, decision and action points.
- We saw in the minutes from the Medical Advisory Committee (MAC) that decisions to grant or stop practicing privileges had been discussed and appropriate action taken, where the MAC had identified concerns about performance or conduct.
- A schedule of audits was in place and clearly laid out in an audit calendar. Audit questions for all audits were under review to ensure they applied to the services provided by the hospital.
- The outpatient and diagnostic services had a risk register that included all known areas of risk identified in the service. Heads of department kept a record of the action being taken to reduce the level of risk and monitored compliance to any due dates. Members of the quality and risk committee reviewed regularly the

risks as part of their meetings. Higher rated risks were added to the newly developed hospital-wide risk register where the hospital's senior management committee reviewed them.
- A daily 'huddle' took place each morning at 8:45am attended by the heads of department where a review of what was happening that day and issues were discussed. Notes were circulated to the rest of the staff.
- There were clear governance systems in physiotherapy. The department had completed the quality assurance audit tool from the Chartered Society of Physiotherapy (CSP) to review and assure quality in clinical practice and service delivery against the ten quality assurance standards required by the CSP.
- The hospital had a lone-working policy and department specific procedures to keep staff safe. This included CCTV and an alarm for staff to carry when working by themselves, which sounded in three areas of the hospital in the event of an incident. Alarms were kept on charge when not in use to ensure there were always alarms available for staff to use.
- Patients who were seen privately or were self-funded were made aware of the terms and conditions of the services being provided to them when they checked in for their appointments. This information was contained in the registration form.

Leadership of service

- Each service had a lead who provided day-to-day leadership to members of staff within the department. Staff felt well supported by their head of department and told us they could raise concerns with them.
- Staff in all clinical areas across outpatient and diagnostic services spoke highly about and had confidence in the senior management team and appreciated the visits of the Chair of the Trustees.
- All heads of department met regularly with all members of their team, both on an individual and team basis.
- Staff told us they were happy to work additional hours or shifts, as they felt an integral part of the organisation.

Culture within the service

- Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and everyone's responsibility. There was an open culture in raising patient safety concerns, and staff were encouraged to report any identified risks.
- Staff worked well together and felt valued team members. Staff commented how everyone supported each other. This was reflected in low vacancy, sickness and turnover rates in all departments.
- Staff were proud to work at the hospital and felt senior management and the trustees were open and transparent with them during the recent period of change.

Public engagement

- There were examples of patients being closely involved in service development. These included patient survey feedback such as the NHS Friends and Family Test and learning from complaints.
- The hospital had designed and introduced a more detailed patient survey that was department-specific (April 2015). The feedback obtained from the survey for endoscopy unit (November to December 2015) and physiotherapy (December 2015 to January 2016) was overall positive with a number of comments indicating high patient satisfaction.
- The hospital also monitored and responded to comments left on the NHS Choice website.

Staff engagement

- Staff of all grades felt involved in decisions about their department and the hospital as a whole.
- Staff told us they were kept regularly updated about any changes through meetings and access to minutes from meetings. For example, the hospital management team had arranged staff forum meetings to inform the staff about changes and action following the CQC inspection in July and August 2015.

Innovation, improvement and sustainability

- The pace of change and improvement over the last six months had been significant. There was evidence that the changes were sustainable due to the new governance structure that the senior management team had introduced. All staff understood the importance of monitoring the quality and safety of the service and raising concerns to ensure safe care and treatment for patients.
- Staff were aware of possible development plans for the hospital. These included an extension that might include a new endoscopy unit.

Outpatients and diagnostic imaging

- The hospital had secured a number of consulting rooms at a local GP practice for consultants to use to offer out-patient appointments more locally for patients, to increase income for the hospital and to promote the services offered.
- In main outpatients, waiting area television was used as a media to promote services offered at the hospital and local businesses.
- The physiotherapy department had advertised its Well Woman and Pilates classes in local magazines to increase awareness of these services in the local area.

Outstanding practice and areas for improvement

Outstanding practice

The resident medical officer (RMO) induction included a week shadowing the current RMO so they had an opportunity to familiarise themselves with the hospital's procedures, policies and practices.

Areas for improvement

Action the hospital SHOULD take to improve

- Introduce a clinical audit programme to monitor the standard of care, treatment and outcomes and take action in response to areas of poor performance.
- Ensure plans for safe handling of specimens in the operating theatre are implemented and ensure the hospital is compliant with any guidance.
- Ensure all staff are up to date with their mandatory training.

Review the level of training provided for staff in the endoscopy unit and consider the provision of additional training

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** Staff did not understand their responsibilities under Duty of Candour and there was not a formal process for staff to follow.

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • Staff in the operating theatre were not fully complying with the five steps to safer surgery. Timeout was undertaken while the surgeon was still 'scrubbing up' and the 'sign out' was undertaken as the patient was being transferred so there was no silent focus and debriefs, which should take place at the end, did not happen. • Not all of the medical gas cylinders were safely stored.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** All staff had not completed their mandatory training and completion levels were not as expected by the provider

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There was no evidence of the consideration of risk to the business, and the quality of the service provided.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing A warning notice was served under Regulation 18 1, 2. (b). • The operating department theatre was not staffed in line with guidance from the Association for Perioperative Practice 2011. • The practitioner supporting the anaesthetist did not have a recognised anaesthetic qualification or equivalent competency assessment. • Practitioners in the operating department theatre were acting a surgical first assistant without having successfully achieved a programme of study that has been bench marked against nationally recognised competencies underpinning the knowledge and skills required for the role.

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment A warning notice was served under Regulation 12 1, 2. (a) (b) (c) (g) • In the operating department medicines were not being safely managed. There were three boxes of out of date drugs in the one cupboard in the anaesthetic room. Medicines in the cupboard in the anaesthetic room were not being stored in a safe way. This was because the medicines held in stock were not being rotated to ensure that the oldest was used first. • Patients were being placed at risk by the instrument count procedure not being followed. The scrub

This section is primarily information for the provider

Enforcement actions

practitioner was undertaking a dual role without risk assessments or policies in place to support this practice therefore the potential risk was not being assessed so that it could be managed.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance A warning notice was served under Regulation 17 1, 2. (a) (b) (f) • Practices were taking place in the operating theatre that were not reflective of the hospitals policies and procedures. • There was no evidence of detailed service specific audit or review by an external theatre practitioner for the operating department. • There was no agreed trigger for review of practices against policies. Neither was there any evidence of continued ongoing review of policies against guidance including guidance from the National Institute for Health and Care Excellence (NICE). • There was no formal analysis of the reported incidents to identify trends which could be used as an aid to learning and delivering a quality service. • The medicines management audit was not effective as issues identified during the inspection had not been picked upped. • In the endoscopy unit there was no audit of patient comfort scores and no audit undertaken at the hospital of individual consultant completion rates and polyp detection rates. • The minutes of the clinical governance meetings reviewed did not contain evidence of clear discussion on findings from audits, incidents or complaints. There was not a clear system for tracking when the equipment used in the operating theatre was serviced.