Oaklands Hospital

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Oaklands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 17 inpatient beds. Facilities include three operating theatres with laminar flow and a designated endoscopy theatre, one inpatient ward with 17 beds, a day case unit and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery and outpatients and diagnostic imaging. We inspected both of these services.

We inspected this service using our comprehensive inspection methodology. This inspection was unannounced. We carried out the inspection on 03 and 04 July 2017.

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

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

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

Services we rate

We rated this hospital as Good overall. This is because whilst the hospital has made significant progress and improvement since their last inspection, there are still areas which require further work and improvement.

We found the following areas of good practice:

- Incidents were reported, investigated and learned from in an appropriate way.
- Infection control and prevention was managed effectively with low rates of hospital acquired infections.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- There had been a significant improvement in the management of medications.
- Levels of mandatory training had greatly improved since the last inspection.
- Correct numbers of suitably qualified staff were deployed.
- Evidence based practice was followed and appropriate audits of compliance with best practice were undertaken.
- Nutrition and hydration were effectively managed.
- There was good multi-disciplinary team working observed throughout the service.
- Staff obtained informed consent from patients prior to undertaking interventions and surgery.
- Patient outcomes were good.
- Staff in the surgical service had good knowledge of both the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The service was responsive to the needs of patients and the local population and patients experienced minimal waits.

Summary of findings

- The service was well led with clear and credible leaders, who were visible and supportive of staff.
- There had been significant improvements since the last inspection and robust plans were in place to sustain these improvements.
- Staff and the public were sufficiently engaged.
- There was appropriate equipment to safely provide care and treatment for patients in the departments.
- The hospital participated in national audits.
- The hospitals Friends and Family test showed that patients were happy with the care they received.
- Staff had a good knowledge of the complaints process so could direct patients if they had a complaint about the service.
- The service was well led with robust governance and risk processes in place.

We found the following areas of practice that require improvement:

- In one theatre area we found dust and brown splashes on the walls. We raised this with the hospital management team and they dealt with the issue quickly.
- Although the management and recording of controlled drugs had improved significantly, there were still areas for improvement in one area of the theatres. Timings relating to controlled drugs and other medication administration in theatre were poorly recorded in half the records we reviewed.
- Some nursing records used in the pre-operative phase did not contain sufficient details about patients' care and lacked dates and times.
- We reviewed ten sets of patient records and in six out of ten records we found at least one section of the records had not been completed.
- We found in some cases key risk assessments had not been completed fully, including the anaesthetic pre-assessment record form, venous thromboembolism.
- We observed teams undertake the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. We observed that the 'time out' phase was not always completed fully.
- Although improved, nurse staffing in the theatre areas remained a challenge.
- Uptake levels for some mandatory training subjects were significantly lower than expected.
- Although improved, the percentage of staff that had an annual appraisal remained low.
- The arrangements for stock reconciliation for medications was not always clear in the outpatient department.
- Not all staff were aware of what constituted a reportable incident.
- The percentage of staff that had received an annual appraisal was lower than the expected target of 90% however this had improved since the last inspection.
- Staff within the Outpatient service had a varied level of knowledge in relation to the Mental Capacity Act.

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

Ellen Armistead

Summary of findings

Deputy Chief Inspector of Hospitals (North West)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because: • Incidents were reported, investigated and learned from in an appropriate way. • Infection control and prevention was managed effectively with low rates of hospital acquired infections. • Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality. • There had been a significant improvement in the management of medications. • Levels of mandatory training had greatly improved since the last inspection. • Correct numbers of suitably qualified staff were deployed across the service. • Evidence based practice was followed and appropriate audits of compliance with best practice were undertaken. • Nutrition and hydration were effectively managed. • There was good multi-disciplinary team working observed throughout the service. • Staff obtained informed consent from patients prior to undertaking interventions and surgery. • Patient outcomes were good. • Staff had good knowledge of both the Mental Capacity Act and Deprivation of Liberty Safeguards. • The service was responsive to the needs of patients and the local population and patients experienced minimal waits. • The service was well led with clear and credible leaders who were visible and supportive of staff. • There had been significant improvements since the last inspection and robust plans were in place to sustain these improvements.

Summary of findings

- Staff and the public were sufficiently engaged.

However:

- In one theatre area we found dust and brown splashes on the walls.
- Although the management and recording of controlled drugs had improved significantly, there were still areas for improvement in one area of the theatres.
- Timings relating to controlled drugs and other medication administration in theatre were poorly recorded in half the records we reviewed.
- Some nursing records used in the pre-operative phase did not contain sufficient details about patients' care and lacked dates and times.
- We reviewed ten sets of patient records and in six out of ten records we found at least one section of the records had not been completed.
- We found in some cases key risk assessments had not been completed fully.
- We observed that the 'time out' phase was not always completed fully in relation to the World Health Organization (WHO) checklist.
- Although improved, nurse staffing in the theatre areas remained a challenge.
- Uptake levels for some mandatory training subjects were significantly lower than expected.
- The percentage of staff that had an annual appraisal remained low.

Outpatients and diagnostic imaging

Good

We rated this service as good because:

- Infection rates were low. Clinical areas and waiting areas were visibly clean.
- There was appropriate equipment to safely provide care and treatment for patients in the departments.
- Staffing was sufficient and patients received care according to national guidelines.
- The hospital participated in national audits.
- There was good multidisciplinary working between consultants, nursing staff and allied health professionals.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.

Summary of findings

- The hospitals Friends and Family test showed that patients were happy with the care they received.
- Staff had a good knowledge of the complaints process so could direct patients if they had a complaint about the service.
- The service was well led with robust governance and risk processes in place.

However:

- The arrangements for stock reconciliation for medications was not always clear in the outpatient department.
- Not all staff were aware of what constituted a reportable incident.
- The percentage of staff that had received an annual appraisal was lower than the expected target of 90%.
- Staff within the service had a varied level of knowledge in relation to the Mental Capacity Act.

Summary of findings

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Good

Oaklands Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Oaklands Hospital

Oakland's Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1991. It is a private hospital in Salford, Greater Manchester. The hospital primarily serves the communities of the Salford and Greater Manchester areas. It also accepts patient referrals from outside this area.

The hospitals registered manager is David Winters, who has been in post since June 2017. The nominated individual is Vivienne Heckford.

We carried out an unannounced inspection of Oakland's Hospital on 3 and 4 July 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Katherine Williams, one other CQC inspector, a CQC Inspection Manager, Stefan Verstraelen, and three specialist advisors with expertise in surgical care, nursing care and radiology. The inspection team was overseen by Lorraine Bolam, Interim Head of Hospital Inspection.

Information about Oaklands Hospital

Oakland's Hospital provides outpatient consultations, physiotherapy, diagnostic imaging, day surgery and inpatient surgery for NHS funded and private patients across a range of medical and surgical specialities including orthopaedic, cosmetic, general and gynaecological surgery. The hospital has one inpatient surgical ward with 17 beds, an eight-bedded day case unit and four theatres, three of which have laminar flow. The hospital provides a range of diagnostic imaging services including X-ray, DEXA scanning (a type of X-ray that measures bone mineral density) and ultrasound. The hospital is registered to provide the following regulated activities:

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

We inspected two core services at the hospital: surgery, and outpatients and diagnostic imaging.

During the inspection we visited the ward, theatres, outpatient department, physiotherapy and diagnostic imaging departments. We interviewed the registered manager, Matron and nominated individual.

We spoke with 23 staff, including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We observed care and treatment and spoke with 15 patients. We reviewed 10 sets of patient records and reviewed staff files and competencies.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected eight times and the most recent inspection took place in October 2016, which found that the hospital as inadequate in relation to surgery and requires improvement in the outpatient service. We found that all areas of concern had improved during this inspection.

In the reporting period July 2015 to June 2016 there were 6435 inpatient and day case episodes of care recorded at the Hospital.

There were outpatient 51,372 attendances in the reporting period; of these were other funded and were NHS-funded. The hospital provided care to adults over the age of 18.

Over one hundred surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising

Summary of this inspection

privileges. There was one regular resident medical officer (RMO), who worked on a weekly rota along with RMOs supplied by an agency to cover the recovery area in theatres.

There were a total of 366 clinical incidents between July 2016 and June 2017. Of these, 118 resulted in no harm, eight in low harm and two in moderate harm. One had resulted in severe harm and there had been one death at the hospital during this time.

There were no incidences of hospital acquired methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (codify) or e-coli between July 2016 and June 2017.

The hospital had received 79 complaints between January 2016 and July 2017. We received six complaints about the hospital.

A mobile computerised tomography (CT) scanner and a mobile magnetic resonance imaging (MRI) scanner visit the hospital each week. These are operated by another provider and were not inspected as part of the inspection of Oakland's Hospital.

Services provided at the hospital under service level agreement:

- Pathology and histology
- RMO provision
- Medical records storage
- Medical photography
- Clinical and non-clinical waste removal
- Interpreting services
- Maintenance of medical equipment

What people who use the service say

People we spoke with during the inspection told us that they were treated with compassion and gave very positive feedback about both services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because :

We observed that the 'time out' phase was not always completed fully in relation to the World Health Organization (WHO) checklist.

Although improved, nurse staffing in the theatre areas remained a challenge.

Although the management and recording of controlled drugs had improved significantly, there were still areas for improvement in one area of the theatres.

Timing relating to controlled drugs and other medication administration in theatre were poorly recorded in half the records we reviewed.

Some nursing records used in the pre-operative phase did not contain sufficient details about patients' care and lacked dates and times.

We reviewed ten sets of patient records and in six out of ten records we found at least one section of the records had not been completed.

We found in some cases key risk assessments had not been completed fully.

Uptake levels for some mandatory training subjects were significantly lower than expected.

In one theatre area we found dust and brown splashes on the walls.

The arrangements for stock reconciliation for medications was not always clear in the outpatient department.

Not all staff were aware of what constituted a reportable incident.

Incidents were reported, investigated and learned from in an appropriate way.

Infection control and prevention was managed effectively with low rates of hospital acquired infections.

Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.

There had been a significant improvement in the management of medications.

Summary of this inspection

Levels of mandatory training had greatly improved since the last inspection.

Correct numbers of suitably qualified staff were deployed across the service.

Infection rates were low. Clinical areas and waiting areas were visibly clean.

There was appropriate equipment to safely provide care and treatment for patients in the departments.

Are services effective?

Good

We rated effective as good because in both surgery and outpatients and diagnostic imaging:

Evidence based practice was followed and appropriate audits of compliance with best practice were undertaken.

Nutrition and hydration were effectively managed.

There was good multi-disciplinary team working observed throughout the service.

Staff obtained informed consent from patients prior to undertaking interventions and surgery.

Patient outcomes were good.

Staff had good knowledge of both the Mental Capacity Act and Deprivation of Liberty Safeguards in the surgery service.

Complaints were handled effectively.

Are services caring?

Good

We rated caring as good because:

Patients were treated with dignity and respect.

Feedback from patients was consistently good.

Emotional support was available and offered to patients and their families.

Patients were involved in their plans of care and their families were encouraged to be part of their care and treatment.

Are services responsive?

Good

We rated responsive as good because:

There was sufficient capacity in the wards and theatres to ensure patients admitted for surgery could be seen promptly and be cared for in the most appropriate environment.

Summary of this inspection

The provider consistently met the national standard of 92% of incomplete pathways patients beginning treatment with 18 weeks of referral.

The surgical services also consistently met the indicator of 90% of admitted NHS patients beginning treatment within 18 weeks of referral.

Services had been planned to meet the needs of local people. The senior staff at the hospital had made efforts to integrate the hospital into the local community.

Complaints were investigated appropriately and lessons learnt were shared with some staff.

However:

The amount of time patients had to wait to be seen in clinics was not measured or monitored.

Are services well-led?

Good

We rated well-led as good because:

Services were well led and leaders were visible and credible.

It was clear that both the senior management team and the staff working at Oakland's Hospital had made significant improvements since the last inspection. All staff we spoke with were positive about these improvements and had embraced the chance to make the hospital a better place for both staff and patients.

All staff were invited to take part in an annual engagement survey. The hospital scored 87% for overall engagement. This was higher than the overall engagement score for the Ramsay group and was also an increase of over 35% on the January 2016 survey.

The survey showed that the responses from staff working at the hospital were overall significantly more positive than the responses received from other areas of the Ramsay group. An example of this was the response to the question as to whether staff would recommend the hospital to friends and family. The hospital scored 90% compared to a Ramsay group average of 82%. In addition over 80% of staff stated that they were motivated by the Ramsay group to do the best job they could.

Strategic risk were well managed and acted on appropriately.

There were robust governance arrangements in place.

Staff felt valued and proud to work for the hospital.

Most staff were aware of the provider's vision and values.

The provider engaged effectively with staff and patients.

Summary of this inspection

There were areas of innovation and there were plans in place to ensure sustainability of the services provided.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Surgery

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

Summary of findings

We rated this service as good because:

- Incidents were reported, investigated and learned from in an appropriate way.
- Infection control and prevention was managed effectively with low rates of hospital acquired infections.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- There had been a significant improvement in the management of medications.
- Levels of mandatory training had greatly improved since the last inspection.
- Correct numbers of suitably qualified staff were deployed across the service.
- Evidence based practice was followed and appropriate audits of compliance with best practice were undertaken.
- Nutrition and hydration were effectively managed.
- There was good multi-disciplinary team working observed throughout the service.
- Staff obtained informed consent from patients prior to undertaking interventions and surgery.
- Patient outcomes were good.
- Staff had good knowledge of both the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The service was responsive to the needs of patients and the local population and patients experienced minimal waits.
- The service was well led with clear and credible leaders who were visible and supportive of staff.
- There had been significant improvements since the last inspection and robust plans were in place to sustain these improvements.
- Staff and the public were sufficiently engaged.

However:

- In one theatre area we found dust and brown splashes on the walls.
- Although the management and recording of controlled drugs had improved significantly, there were still areas for improvement in one area of the theatres.
- Timings relating to controlled drugs and other medication administration in theatre were poorly recorded in half the records we reviewed.
- Some nursing records used in the pre-operative phase did not contain sufficient details about patients' care and lacked dates and times.
- We reviewed ten sets of patient records and in six out of ten records we found at least one section of the records had not been completed.
- We found in some cases key risk assessments had not been completed fully.

Good

Surgery

- We observed that the 'time out' phase was not always completed fully in relation to the World Health Organization (WHO) checklist.
- Although improved, nurse staffing in the theatre areas remained a challenge.
- Uptake levels for some mandatory training subjects were significantly lower than expected.
- The percentage of staff that had an annual appraisal remained low.

Are surgery services safe?

Requires improvement

We rated safe as **requires improvement.**

Incidents

- All substantive staff had access to the hospital's electronic incident reporting system. Agency and bank staff were able to access the system by requesting access from substantive staff.
- Staff received training on how to use the system as part of their induction to the hospital.
- Managers reviewed all incidents and we saw evidence that appropriate responsive actions were taken as a result of incidents.
- Staff told us they received meaningful feedback relating to any incidents they raised. This feedback included what action had been taken.
- Staff were aware of the types of incident they should report and were able to give us recent examples where they had raised incident reports.
- Lessons learned from incidents and complaints were shared with staff during briefings and staff meetings.
- There was a separate monthly lessons learned meeting held by senior managers within the hospital. This meeting was designed specifically to learn from incident within the hospital and across the Ramsay Healthcare group.
- For the period 30 November 2016 to 30 June 2017, services across the hospital reported 361 incidents. Of these two were assessed by the management team as requiring further investigation and classified as Serious Incidents Requiring Investigation. We reviewed one of these investigations reports and found that the investigation was thorough and undertaken appropriately with relevant lessons learned documented.

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

Good

Surgery

- The surgical services were recording and monitoring key areas of safety data. This information was scrutinised by the managers within the service and also the hospital manager through a number of reports and meetings.
- Areas monitored included rates of venous thrombo embolism (VTE), pressure ulcers and falls.
- There had been no VTE's reported in the period 1 November 2016 to 30 June 2017.
- For the same period, data showed there had been no reported falls or pressure ulcers in the surgical services.

Cleanliness, infection control and hygiene

- There had been no cases of methicillin-resistant staphylococcus aureus (MRSA) bacteraemia infections, methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia infections or clostridium difficile (C.diff) infections at the hospital between 1 November 2016 and 30 June 2017.
- Surgical site infection rates were low and each infection was subject to a root cause analysis investigation. For the same time period, the service undertook 107 primary hip replacement operations. In one case a patient developed a surgical site infection; this equates to an infection rate of less than 1%. In the same period the service undertook 184 primary knee replacement surgeries and none of these patients developed a surgical site infection. The service also had 0% infection rates for head and neck surgery and abdominal surgery
- The ward and theatres we inspected were visibly clean.With the exception of one theatre area which contained equipment with brown splashes present and low level dust. We highlighted this to the hospital manager, who ensured this was actioned immediately.
- Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. We saw these routinely completed correctly and were monitored by the theatre manager.
- There were sufficient numbers of hand wash sinks and hand gel dispensers and we observed staff utilising these appropriately.
- Staff were aware of current infection prevention and control guidelines and were able to give us examples of how they would apply these principles.
- Staff were observed using personal protective equipment, such as gloves and aprons, and changing this equipment between patient contacts.
- Staff strictly followed procedures for gowning and scrubbing in the theatre areas to minimise the risk of infections.
- The service undertook early screening for infections including MRSA during patient admissions and preoperative assessments. This meant staff could identify and isolate patients early to help prevent the spread of infections.
- Regular infection control and prevention audits were undertaken and these showed consistently high levels of compliance in the theatre areas.
- The ward area of the service was visibly clean and tidy and cleaning audits were monitored by the ward manager. Infection control and prevention audits in the ward area showed consistently high compliance levels and clear actions taken when non-compliance was identified.

Environment and equipment

- Equipment on the wards and in theatre areas appeared to be well maintained. There were regular maintenance checks carried out where required and clear records of these checks were kept securely.
- Theatre equipment which required specialised decontamination was well managed and the process for this decontamination was clearly set out and known to all staff.
- Staff carried out regular checks on key pieces of equipment in all areas. Emergency resuscitation equipment was in place and records indicated it had been checked daily in all areas, with a more detailed check carried out weekly as per the hospital policy.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Electrical safety testing and personal appliance testing was up to date for all devices we checked in the theatre and ward areas.

Medicines

Good

Surgery

- During our last inspection we found serious concerns relating to the safe and proper management of medicines. During this inspection we found that the hospital had made significant improvements in this area.
- In the ward area, we found that medicines were being managed effectively and safely. Medicines were stored securely and in the correct storage area. We found prescription charts were clearly completed with allergy status clearly recorded. Staff also undertook appropriate checks when administering medicines to patients.
- In the theatre areas we found that the management of medicines was much improved from the last inspection. We found that medicines were stored securely in all areas.
- During the last inspection we had concerns that controlled drugs were not being managed safely and found numerous errors and omissions in numerous controlled drug records books. During this inspection we reviewed four controlled drugs record books in theatre and recovery areas. The books used in the theatre areas were completed fully in most entries. Where they were not completed fully this had been recognised, reported and actioned appropriately.
- The controlled drug record book used in the recovery area showed a number of omissions and issues with the recording of controlled drugs. These included times of administration, signatures for supply, administration and destruction, dosage details and documentation of amounts of controlled drugs administered. We highlighted this to the theatre manager who immediately commenced an audit of the books and arranged a reflection session with staff to learn from the omissions. Following the inspection the senior management team advised that an ongoing audit would be implemented to monitor this area of concern.
- The hospital commissioned pharmacy provision from a neighbouring NHS trust. The hospital had an on-site pharmacy so that medicines required for patients were readily available. The pharmacy team also carried out a quarterly audit of controlled drug records books. The audits we reviewed showed good levels of compliance and any areas for improvement were actioned and re checked appropriately.
- We saw that medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out regular reviews of stock on the ward.

Records

- Medical records were paper based and were securely stored behind the nurses' station in the ward area and travelled with the patient through their theatre journey.
- During the last inspection we found that records were not well managed and were not always up to date. During this inspection we found that the records management had improved in some areas, however, areas for improvement remained.
- Records were well organised and easy to navigate. The records completed by nursing staff were well completed in the ward area. However, some nursing records used in the pre-operative phase did not contain sufficient details about patients' care and lacked dates and times.
- We reviewed ten sets of patient records and in six out of ten records we found at least one section of the records had not been completed. In all cases this related to the pre-operative phase.
- In three cases, we found the anaesthetic pre-assessment record form lacked important details, such as planned anaesthesia, airway assessment and medical history.
- Timings relating to controlled drugs and other medication administration in theatre were poorly recorded in five out of ten records.
- Staff signatures were illegible in four out of ten records.
- The senior management team undertook weekly reviews of medical and nursing records. They advise that they were aware that this was still and area for improvement and were working hard to action this. They advised that they had recently switched to a 'live'

records audits process. This meant that the governance team would review and audit records during the patients journey and highlight any areas for improvement to staff as the audit was undertaken.

- The senior management team actioned our concerns immediately and put into place a clear action plan within 24 hours of the concerns being raised. This action plan was clear and had measurable actions set out.
- When we reviewed records following this in the theatre areas, we found they were fully completed.
- The May 2017 audit showed that 100% of anaesthetic records audited contained an anaesthetic assessment form and appropriate consent. The audit also showed that 100% of records showed that the breathing and essential equipment was subjected to relevant checks prior to surgery. The audit also looked at the documentation of pre surgical medications and patient allergies, results showed that these were documented appropriately in 100% of records.
- Some areas of the audit showed areas for improvement, these included; documentation of height and weight, documentation of nil by mouth status and accurate fluid balance recording. All these areas scored less than 80% compliance. The theatre and registered manager had an ongoing action plan to address any areas of concern identified through these audits.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction followed by three yearly safeguarding refresher training for safeguarding children and adults.
- Clinical staff were required to undertake level two training for safeguarding children and safeguarding vulnerable adults. The outpatient manager was also required to undertake level three training. This met the intercollegiate guidelines for safeguarding training, which outline that staff that have continued interaction with children require level two safeguarding children training.
- The uptake rates for safeguarding children training on the ward area were 100%; however within the theatre areas this uptake level was significantly lower at 70%.
- The only staff to undertake level three safeguarding children training were the outpatient manager and hospital matron, both these staff had undertaken this training in the time period required. There was a designated nurse for safeguarding children within the Ramsay Health Care UK group.
- In the theatre areas only 83% of staff had undertaken safeguarding vulnerable adult training, however, 100% of staff working in the inpatient ward had completed this training.
- Senior managers within the service explained that there was an ongoing training programme to address the lower uptake levels and all new staff received this training at the point of induction.
- Staff in all areas were aware of how to identify issues of potential abuse and neglect and how to report safeguarding concerns and access support and advice.
- There was a Ramsay Healthcare wide policy for safeguarding and staff were aware of how to locate this.
- Information on how to report safeguarding concerns was clearly displayed in the ward and theatre areas we inspected.

Mandatory training

- Mandatory training was delivered on a rolling program and was delivered through a blended learning approach of e-learning and face to face training.
- Mandatory training uptake levels were high across most subjects in the ward area. The rates for basic life support for the ward area was 100%, the ward area also had 100% of staff trained in infection control and basic manual handling. Uptake levels for other subjects were also consistency over 90%, these subjects including medication management, customer care, fire safety and medical gases. Some subjects had a lower uptake level, however, the registered manager told us that they were working to improve these levels and had an action plan in place.
- In the theatre areas training uptake levels were lower than the ward areas. When we spoke with managers within this area they advised this was due to a recent

recruitment and that they were working to improve uptake levels. This was being done through regular reviews of staff files and providing additional training sessions.

- During the last inspection we were concerned that staff did not have the correct levels of life support training in the theatre areas. During this inspection we were assured that there were sufficient numbers of suitably qualified and trained staff on each shift. Uptake levels for life support had improved significantly since our last inspection. The uptake level for basic life support was 91%; however, 93% of staff had received immediate life support training, which was of a higher level that basic life support. In addition a further 60% of staff had undertaken advanced life support training.
- The uptake levels for basic manual handling were also high at 91%. However, in some subjects the uptake levels were significantly lower than the providers 90% target. These subjects included the handling of sharps training, which was at 54%, medication management at 75% and data protection at 70%.

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

- Staff were expected to carry out preoperative risk assessments prior to surgery, to identify patients at risk of harm. Patients at high risk were required to be placed on care pathways and care plans to ensure they received the right level of care. We found that these were not always completed.
- In two out of ten records, the venous thromboembolism risk assessment was not completed fully. However, the provider's internal audit for June 2017 showed that 100% of records reviewed contained fully completed VTE assessments.
- We found that other risk assessments, such as falls and moving and handling assessments were completed consistently in all records reviewed.
- Patients were required to be assessed by an anaesthetist and surgeon on the day of surgery to identify patients with underlying medical conditions or those who were at risk of developing complications after surgery. This contributed to the decision on whether or not a patient could be operated on at the hospital.
- During the last inspection we found that anaesthetic assessments were consistently poorly documented. During this inspection we found that this had improved, but there were still areas of concern. We reviewed ten anaesthetic assessments and found that in four out of ten cases key information was missing.
- During the last inspection we found that in theatre there were not always the correct levels of staff with life support training. During this inspection we found that all staff working in the theatre areas had the required level of life support training.
- Theatre staff were required to carry out 'safety huddles' on a daily basis, to ensure all staff had up-to-date information about risks and concerns. We observed that these safety huddles were attended by all staff and were well structured and informative.
- During the last inspection we found concerns that the World Health Organization (WHO) checklist and process was not always followed during operations. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors before, during and after surgery. During this inspection we found that compliance with this key checklist had improved significantly. However, there remained some areas for concern.
- We observed five theatre teams undertake the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures. However, in two theatres we observed that the 'time out' phase was not always completed fully. In one case this was observed to be rushed and staff were distracted. We raised this with the senior management team who actioned this immediately.
- We reviewed ten sets of records and we found that in all ten patient records the WHO checklist section within the records had been completed fully.
- An early warning score (EWS) system was in use in all areas. The EWS system was used to monitor patients' vital signs identify patients at risk of deterioration and

prompt staff to take appropriate action in response to any deterioration. Staff carried out monitoring in response to patients' individual needs to quickly identify any changes in their condition.

- The hospital had a service level agreement with a neighbouring trust to transfer patients who became unwell. The staff were aware of how to escalate patients who became unwell and were able to tell us when they would call an ambulance or senior assistance.
- There was a resident medical officer (RMO) on site, 24 hours a day, to respond to urgent calls and emergencies. The hospital had a transfer agreement in place so deteriorating patients could be transferred to a local acute trust if needed.
- There was also a further RMO working within the recovery area to assist in the event that a patient became unwell.

Nursing and support staffing

- During the last inspection we were not assured that the correct number of suitably qualified staff were always deployed in the theatre areas. There was also a high usage and reliance on bank and agency nursing staff to support the permanent staff. During this inspection we found that nurse staffing had significantly improved.
- The expected staffing levels for theatre lists and areas were set out in the provider's standard operating policy for theatres. The policy was in line with guidance set out by the Association for Peri-operative Practitioners (AfPP) (2014).
- The standard requirement for each theatre list was two scrub practitioners, one circulating practitioner and one anaesthetic assistant (ODP), as a minimum for cases involving the administration of an anaesthetic and major procedures. The staffing levels for minor cases not requiring anaesthetic remained the same with the exclusion of an OPD.
- The service ran routine lists of both minor and major procedures. We found that all lists in a two month period were appropriately staffed by suitably qualified staff.
- The total vacancy rate for surgical services was high at 29% however; the hospital had an active recruitment campaign in progress.
- The theatre areas were still using high numbers of bank and agency staff. However, we found that the arrangements for ensuring these staff were suitably qualified and competent to undertake their roles were much improved and were conducive to safe ways of working.
- Records showed that staff turnover rates were 31% across the surgical services for the period June 2016 to July 2017. This meant that 31% of the total staff employed changed employment during this period. This had, however, improved from 2015 when the rate was over 50%.
- The ward area had a sufficient number of trained nursing and support staff with an appropriate skills mix to ensure that patients received the right level of care.
- The staffing establishment was set in advance, based on planned procedures and patient acuity. Senior managers told us staffing levels were increased if a patient requiring additional support was identified during their pre-operative assessment.

Medical staffing

- Medical cover on the ward was provided by a resident medical officer (RMO). During their shift, the RMO was based at the hospital 24 hours per day. The RMO was on duty between 7.30am and 10pm daily and was on-call during out-of-hours periods.
- Ward staff told us the RMO cover was sufficient to meet patient needs, because the majority of patients were assessed as low risk and did not have complex medical needs.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists, who were mainly employed in substantive posts by other organisations (usually in the NHS) and had practising privileges (an agreed licence to practice in a hospital subject to rules and requirements). Medical staff were required to provide proof they had undertaken operations elsewhere in the same clinical field.
- There was a further RMO employed to work in the theatre recovery area during all periods of patients care. Staff told us that this was helpful and they felt able to access this RMO for help and assistance if a patient deteriorated.

Good

Surgery

- The consultants and anaesthetists were responsible for their individual patients during their hospital stay. Patient records showed consultant reviews were carried out on a daily basis.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed, including out-of-hours. Arrangements were in place for consultant cover during periods of sickness or leave.

Emergency awareness and training

- The hospital had a business continuity plan that listed key risks which could affect the provision of care and treatment. Staff were aware of how to access this information when needed.
- The ward and theatre staff had written guidelines to follow in the event of a major incident, such as a fire or power failure.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- Patients received care according to national guidelines from organisations, such as the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines.
- Staff in the ward and theatres used enhanced care and recovery pathways, in line with national guidance.
- Staff used integrated care pathways for surgical procedures, such as for hip or knee replacement and these were based on national guidelines.
- Staff we spoke with told us policies and procedures reflected current guidelines and were easily accessible via the hospital's intranet.
- Patients were assessed for their risk of developing a venous thromboembolism (blood clot) on admission. We saw evidence that patients were given treatment in line with NICE quality statement (QS) 66. Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50).

Pain relief

- Staff assessed patients pre-operatively for their preferred post-operative pain relief.
- Staff used pain assessment charts to monitor pain symptoms at regular intervals. We found in some records that pain scoring was not always completed; however, staff were administering pain relief during these periods.
- We observed staff asking patients about their pain and we observed that staff would frequently check on patients' pain levels.
- Staff reacted promptly when patients requested pain relief.
- Patient records we reviewed showed that staff gave patients appropriate pain relief when required. This was confirmed by the patients we spoke with.

Nutrition and hydration

- The hospital's guidelines for fasting before surgery (the time period where a patient should not eat or drink) were clear and reflected national and current guidance.
- Staff identified patients in need of assistance with eating and drinking and acted on these needs appropriately. However, we found that most patients had low dependency needs and did not require assistance with eating and drinking.
- Patients told us staff offered them a variety of food and drink and told us that the quality of food and drink was good.
- We found that fluid input and output charts were completed fully in most cases.
- Meals for patients with dietary requirements were readily available including halal, low sugar, low fat and gluten free options.

Patient outcomes

- The hospital was recording data for patient reported outcome measures (PROMS). The hospital scored within the expected range on the average adjusted health gain for primary knee replacement on each of the three measures, indicating that outcomes following knee

replacement were similar to other providers of NHS treatment. For primary hip replacement, high numbers of patients reported improvement on the three measures of health gain.

- PROMS data was gathered for groin hernias; however, there was insufficient data to make national comparisons.
- Following last inspection the provider had initiated a monthly anaesthetic audit. This audit covered key areas such as documentation of cannulation, consent, quality of anaesthetic records and medication documentation. The results varied across the domains audited and with key areas showing a high level of compliance in the most recent audits.
- There were three unplanned returns to theatre between July 2016 and June 2017 and five unplanned readmissions to the hospital within 28 days of discharge. This was not high when compared with independent acute hospitals we hold this type of data for.
- There had been 11unplanned transfers to other organisations for the same time period. This rate was not high when compared with other independent acute hospitals we hold this type of data for.
- The endoscopy service provided at the hospital was not accredited by the Joint Advisory Group on GI Endoscopy (JAG). JAG accreditation indicates that the service provides endoscopy in line with the Global Rating Scale Standards, but is not an essential requirement. The endoscopy suite at the new hospital had been designed in line with the requirements of JAG and there were plans to apply for accreditation following the move to the new site.

Competent staff

- Newly appointed substantive staff underwent an induction process and their competency was assessed prior to working unsupervised.
- Staff on the inpatient ward told us they received annual appraisals. Staff in the theatre areas told us that they did not always receive an annual appraisal. Records showed that 67% of inpatient ward nurses, 0% of healthcare assistants and 77% of other professionals working on the ward had completed their annual appraisals between April 2015 and April 2016.
- Records showed that 88% of theatre nurses and 66% of healthcare assistants and operating department practitioners had completed their annual appraisals between June 2016 and July 2017. Although these levels were lower than the 90% target, they had significantly improved since the last inspection.
- During the last inspection we had concerns that senior managers in the theatre area were not aware of the competence of agency and bank staff working there. During this inspection we found this had significantly improved and when reviewing staff personnel files we found these up to date and that they contained all relevant qualifications required. The hospital and theatre management team had also implemented an 'agency and bank staff accountability checklist'. We observed this in use and that it was fully completed in the cases we reviewed.
- All consultant surgeons and anaesthetists were required to maintain current practicing privileges in line with the providers practicing privileges policy.Each individual consultant was responsible for keeping their information up to date and current.
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC). This included a review of appraisals, General Medical Council (GMC) registrations and medical indemnity insurance.
- We spoke with consultants, who told us they underwent peer appraisal and revalidation at the NHS acute trust they were based and this information was provided to this hospital to ensure they kept up-to-date records about the consultant.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers.
- We found that staff working on the inpatient ward had up to date personnel files which were maintained and reviewed by the ward manager. These files included set competencies for their roles.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the ward and theatre areas. Staff told us they had a good relationship with consultants and the resident medical officers (RMO).We observed staff working closely and collaboratively.

- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists and specialist input was evident when required.
- Theatre staff were required to carry out 'safety huddles' on a daily basis to ensure all staff had up-to-date information about risks and concerns. We observed that these safety huddles were well attended.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff to ensure patient care could be coordinated and delivered effectively.
- Staff worked closely with staff from a neighbouring trust from which pharmacy support was commissioned.

Seven-day services

- Routine surgery was performed in the theatres during weekdays and on some Saturdays. Surgery was not performed on Sundays.
- The inpatient ward accommodated overnight patients seven days per week and staffing levels were maintained during out-of-hours and weekends.
- The RMO provided out-of-hours medical cover for the inpatient ward 24 hours a day, seven days per week. The second RMO was present in the recovery area during all hours of surgery.
- Patients were seen daily by their consultant, including on weekends. We saw evidence of this in patient records.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed. They told us that they did not experience any difficulties in accessing consultant support outside of normal working hours.
- The imaging department had an on-call radiographer available 24 hours a day, seven days a week for X-ray.

Access to information

- Staff said they had access to the information they needed to deliver effective care and treatment to patients in a timely manner. Staff could assess test results and diagnostic imaging.
- All staff had access to policies, procedures and guidance through the hospital intranet.
- Upon discharge staff completed an electronic discharge summary. This was then printed and a copy was sent to the patients GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A consent policy was available for staff to refer to and easily accessible.
- Consent training was included in the hospitals mandatory training programme, however only 35% of staff in the theatre areas had undertaken this training. This level was higher in the inpatient ward area where 100% of staff had completed the training.
- We reviewed eight consent forms and found that they were correctly completed and met with national guidance.
- Staff were able to describe the process they would follow if they felt a patient was unable to consent. Staff said they would escalate any concerns to the senior nurse or doctor in their area of practice. Staff were aware of when and how to assess patients mental capacity.
- Consultants sought consent from patients undergoing surgery during the initial consultation and again on the day of surgery.
- Staff across the surgical services were fully aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS).Training on these subjects was delivered as part of the level two safeguarding adult's course.
- There was a Ramsay wide do not attempt cardiorespiratory resuscitation policy in place. This was also supported by an advanced directive policy. Advanced directives are legally binding declarations to refuse medical intervention or procedures in certain circumstances.

Good

Surgery

Are surgery services caring?

Good

Caring means that staff involve and treat you with compassion, kindness, dignity and respect. We rated caring as **good.**

Compassionate care

- In February 2017 the hospital had a 30% response rate to the friends and family survey for NHS funded patients. Of those patients, 100% were extremely likely or likely to recommend the hospital. For the twelve month period prior to this 80% of patients surveyed stated that they were extremely likely or likely to recommend the hospital.
- All patients spoke positively about the care and treatment they had received.
- Staff ensured they respected patient's privacy and dignity by knocking on doors before entering.
- We observed staff interacting with patient in a kind and considerate manner. Theatre escorts and nurses had a warm manner with patients who were recovering.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and communicated with patients in a way they could understand.
- Patients told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and about the quality and content of written materials, such as information leaflets specific to their condition and treatment.
- Patients told us the medical staff fully explained the treatment options to them, including risks and benefits so they were able to make informed decisions.
- Staff identified when patients required additional support to be involved in their care and treatment, including translation services for patients whose first language was not English. . Staff were able to tell us how they would access translation services including sign language interpreters for patients with hearing difficulties.
- Pre-operative assessments took place and took into account individual preferences
- Visitors were able to stay on the ward as long as they needed.

Emotional support

- Staff demonstrated that they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives when they were feeling anxious.
- We observed that staff provided emotional support to patients in a professional manner.
- Staff were able to describe how they would provide emotional support to patient and their relatives if they required it.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The hospital had effective arrangements in place for planning and booking of surgical activities, ensuring patients were offered choice and flexibility. The hospital also worked closely with the local NHS clinical commissioning group and NHS providers to ensure that services were planned to meet the needs of the local people.
- Patients had an initial consultation to determine whether they needed surgery, followed by a pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded

from receiving treatment at the hospital using the American Society of Anaesthesiologists (ASA) physical status score. The majority of patients admitted to the hospital had an ASA score of 1 or 2, which meant that patients were generally healthy or had simple pre-existing health conditions. Patients with complex pre-existing medical conditions were excluded from being treated at the hospital and were referred for their care elsewhere.

- The hospital management team had made efforts to engage with the local community and population, to better understand the needs of the local population. Projects included a patient participation group held in collaboration with a local GP surgery on how to look after your joints. Another community project was the recent donation by Oakland's Hospital of a community defibrillator to a local community group.
- The ward was open 24 hours a day, seven days a week and had 17 overnight beds and eight day care beds.

Access and flow

- There were 4279 patients admitted to the hospital for either day case or overnight elective surgery between June 2016 and July 2017.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff to manage patient flow. We observed this communication and found that there were no delays or issues with capacity to accommodate patients.
- Patients were seen quickly and experienced minimal waits in both the theatre and ward areas.
- Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward. We observed that this was then followed up when patients arrived for their planned surgery.
- Staff also spoke with patient ascertain whether they were likely to require additional support at home when they were discharged.
- During the last inspection patient records showed staff did not always fully complete the discharge checklist that covered areas such as medication and communication to the patient and other healthcare professionals, such as GPs, to ensure patients were discharged in a planned and organised manner. We found this was still an issue during this inspection with six out ten records reviewed lacking information on this checklist. However, as last time, we did not find any issues relating to the admission or discharge of patients from the ward or theatres.
- The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- The hospital met the indicator of 90% of admitted NHS patients beginning treatment within 18 weeks of referral for each month between June 2015 and June 2016.
- Records showed that there had been 152 operations cancelled for non-clinical reasons between June 2016 and July 2017, 100% of these cases were rebooked within 28 days of the patient's original surgery.
- Admissions for patients undergoing day case procedures were staggered to minimise waiting times.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.
- Staff could access a language interpreter if needed and were able to describe how they would do this.
- Staff were aware of when they needed to make reasonable adjustments for patients living with a disability. We observed that all areas were accessible by wheelchair and that there were sufficient facilities for patients living with a disability.
- The hospital did not carry out any invasive surgical procedures on patients less than 18 years of age.
- The hospital had a comprehensive dementia strategy and staff working on the ward and in theatres were aware and knowledgeable about this strategy.
- Despite treating very low numbers of patient living with dementia, senior managers told us that they had a focus and drive to ensure patients living with dementia received excellent care. The hospital supported a national charity in dementia research and made a number of donations through fund raising.
- All staff were required to undertake training in the management of patient living with dementia. Training

levels in the theatre areas were low at 60%; however, this was significantly improved since the last inspection when the level was less than 35%. In the inpatient ward area, 100% of staff had undertaken this training.

Learning from complaints and concerns

- The hospital had a complaints policy in place. The hospital manager and matron took overall responsibility for the management of complaints and signed all response letters.
- The hospital's process aimed to acknowledge all complaints within 24 hours and provide a full response within 20 working days.All complaints we reviewed met these timescales.We reviewed one complaint and saw that this was acknowledged within 24 hours.
- The response to complaints were appropriate and offered explanations for patients' negative experiences. These were much improved from the last inspection. They contained apologies where appropriate and also answered the points the patients had raised.
- The hospital also kept an informal complaint log which was reviewed regularly by department managers and the matron.
- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas.
- We saw evidence of learning from complaints and this learning was disseminated through staff meetings and written communications.

Are surgery services well-led?

Good

We rated well-led as **good.**

Leadership and culture of service

- The hospital management team was made up of a registered manager who oversaw the overall business and management of the hospital. He was supported by a matron who oversaw the clinical aspects of the hospital and two service managers. We observed that there was strong and credible leadership of the service from this team.
- The leadership within the surgical services reflected the vision and values set out by the trust. Staff spoke positively about local leaders within the services. Local leaders were visible, respected and competent in their roles.
- There were clearly defined and visible local leadership roles across the surgical services.
- Staff told us that their line managers were visible and approachable. Staff particularly spoke positively of the ward manager and matron.
- Both the Matron for the surgical services and the theatre manager were highly visible during our visit. Staff told us that this was not unusual.
- Staff within the theatre area told us that the culture within the theatre area had improved significantly since the last inspection.
- All staff spoke positively about the management team and the changes that they had implemented. It was clear that the management team were passionate and driven to improve services at the hospital. We heard examples of managers taking the time to ask staff about their well-being and supporting staff during difficult times.
- All staff felt able to confidently raise concerns and felt that they would be listened to and appropriate action taken.
- Staff were proud to work at the hospital and for the Ramsay group.

Vision and strategy for this this core service

- There was a corporate strategy and vision called the 'Ramsay way'. This strategy and vision set out behaviours and values expected of staff working for the organisation. This strategy had a number of values which staff were expected to embody; this included being caring, progressive, enjoying their work and using a positive spirit to succeed.

- There was a separate vision which sat alongside this strategy and this was that Ramsay Healthcare were committed to being a leading provider of healthcare services by delivering high quality outcomes for patients and ensuring long term profitability.
- A further ten management principles underpinned the overall strategy and vision for the hospital and Ramsay group.
- Staff we spoke were aware of Ramsay way and could explain how they used this to guide their day to day work.

Governance, risk management and quality measurement

- There was a robust governance framework within the surgical services. Senior managers were clear on their roles in relation to governance and they identified, understood and effectively managed quality, performance and risk.
- There was also a designated governance manager working within the hospital. This manager was able to support and advise staff on matters relating to governance and risk and audited key areas.
- Managers had risk registers in place for all areas of the surgical services. Managers regularly reviewed, updated and escalated the risks on these registers where appropriate. There were action plans in place to address the identified risks.
- Audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives and they cascaded this to ward and theatre managers through meetings.
- There was clear alignment of risks recorded and what staff told us was concerning them. This showed that managers were in touch with the opinions and concerns of their staff and showed that they acted on these concerns.
- There was a quarterly clinical governance meeting which discussed both clinical and non-clinical risks.
- The matron had also developed a matron's 'walk around' tool and audit which she undertook every month across all areas of the hospital. The matron and hospital manager further monitored compliance with audits and safety through monthly safety and quality reports. These reports included topics such as incidents, complaints and audit compliance.
- Since the last inspection he matron had developed an anaesthetic forum for the anaesthetists working in the hospital. She told us this was specifically in response to our last inspection and the issues identified in the anaesthetics area. We reviewed notes of one of these meetings and found that the meeting discussed key issues and had a clear escalation process if it was felt issues needed to be raised in other areas of the Ramsay group.
- There was a Ramsay wide risk management policy in place. This set out the responsibilities of managers and senior managements in relation to risk management.
- The MAC Medical Advisory Committee was held quarterly and chaired by a lead consultant. We reviewed minutes from this meeting and saw the meeting was well attended. Clinical incidents, quality assurance and findings from the last inspection were discussed.
- There were robust processes in place for granting and reviewing practising privileges and these were also discussed at the MAC committee.
- We reviewed minutes from ward and department meetings we saw that key issues related to incidents, risks, complaints and audits were discussed in detail.

Public and staff engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the results of the NHS Friends and Family test were displayed on notice boards.
- The surgical services participated in the NHS friends and family test for NHS funded patients, which gives people the opportunity to provide feedback about care and treatment they received. The NHS Friends and Family (FFT) scores were 80% for 2017 and the latest figures available for February 2017 showed that 100% of patients were likely to recommend the hospital. This was higher than the England average. The response rate for the hospital was also significantly higher than the England average (between 16% and 22%).

Good

Surgery

- The senior management team told us that they routinely sought consultation on new services or changes to services and were always looking for improvements. An example of this was a patient questionnaire provided to day case patients to seek to understand their experience and preferences.
- All staff were invited to take part in an annual engagement survey. The hospital scored 87% for overall engagement. This was higher than the overall engagement score for the Ramsay group and was also an increase of over 35% on the January 2016 survey.
- The survey showed that the responses from staff working at the hospital were overall significantly more positive than the responses received from other areas of the Ramsay group. An example of this was the response to the question as to whether staff would recommend the hospital to friends and family. The hospital scored 90% compared to a Ramsay group average of 82%. In addition over 80% of staff stated that they were motivated by the Ramsay group to do the best job they could.
- In all areas of the survey the percentage of positive answers had increased since the January 2016 survey.

Innovation, improvement and sustainability

- It was clear that both the senior management team and the staff working at Oaklands Hospital had made significant improvements since the last inspection. All staff we spoke with were positive about these improvements and had embraced the chance to make the hospital a better place for both staff and patients.
- Staff were constantly looking forward to improve and senior managers were open and responsive to suggestions.
- The hospital had held a patient participation group in collaboration with a local primary care service. This was aimed at health promotion and educating the public on how to look after their joints.

Good

Outpatients and diagnostic imaging

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

Summary of findings

We rated this service as good because:

- Infection rates were low. Clinical areas and waiting areas were visibly clean.
- There was appropriate equipment to safely provide care and treatment for patients in the departments.
- Staffing was sufficient and patients received care according to national guidelines.
- The hospital participated in national audits.
- There was good multidisciplinary working between consultants, nursing staff and allied health professionals.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- The hospitals Friends and Family test showed that patients were happy with the care they received.
- Staff had a good knowledge of the complaints process so could direct patients if they had a complaint about the service.
- The service was well led with robust governance and risk processes in place.

However:

- The arrangements for stock reconciliation for medications was not always clear in the outpatient department.
- Not all staff were aware of what constituted a reportable incident.
- The percentage of staff that had received an annual appraisal was lower than the expected target of 90%.
- Staff within the service had a varied level of knowledge in relation to the Mental Capacity Act.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Incidents

- Staff in all departments used the Ramsay Health Care UK group-wide incident reporting policy. All incidents were recorded using a computer based incident reporting system.This was held on the intranet and could be accessed by all staff grades.
- Data received from the hospital reported 16 level four clinical and 28 level four non-clinical incidents in the outpatients department, there were no level four clinical incidents reported in radiology between 1 November 2016 – 20 June 2017. An Incident that was determined as having high impact on patients was categorised as a level 4 incident. There were no level three, two or one clinical incidents reported. However, there were two level three and one level two non-clinical incidents reported during the same reporting period.
- The outpatient and diagnostic and imaging departments reported no serious incidents, never events or mortalities between the 1 November 2016 – 30 June 2017.
- The process of reporting incidents was described by staff, for example staff told us they would complete an incident form online and inform the manager verbally. However, it was evident that staff did not know what constituted a reportable incident. For example at the time of inspection, a patient was booked in for an injection by the consultant, but nursing staff were unaware of the appointment. Staffing at 08.30am was insufficient for this procedure to go ahead and staff at the time agreed. Once the department was adequately staffed staff informed the doctor and the treatment commenced. Staff did not report this as an incident.
- The hospital held lessons learned meetings; representatives from each of the departments attended these meetings and took back any learning to their individual departments. We reviewed minutes of the last departmental team meetings for April, May and June 2017 and saw evidence of incidents, actions and outcomes being discussed with the wider team.
- The duty of candour is a regulatory duty relating 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. There had been no incidents in the diagnostic imaging department in the last six months before the inspection which had triggered the duty of candour regulation.
- Staff were familiar with the importance of exercising the duty of candour and had a good understanding of the principles of being open and honest with patients.

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean and tidy apart from the clinical dressing room, which was untidy and extremely cluttered. This meant the health and safety of staff and patients was potentially compromised. However, senior managers were notified of our findings and when we returned the room was clean, tidy and spacious.
- All cleaning schedules were completed daily; we reviewed completed schedules for May and June 2017 for each of the six clinic rooms in the outpatients department.
- The OPD department infection control audit for June 2017 showed a 60% compliance rate against a target of 90%. When staff were asked why this was, they suggested it was because the lead was specially trained in this area and was able to point out non- compliance. The diagnostic and imaging department reported 100% compliance in the reporting period of March and April 2017.
- The hospital used a Ramsay Health Care UK group-wide IPC policy, which set out the standard precautions to be taken by staff to prevent the spread of infections. Guidance set out on hand hygiene, use of personal protective equipment and safe disposal of clinical waste and sharps was clear for staff to follow.
- Staff across the hospital were all expected to complete the infection control module and hand hygiene training

each year, as part of their mandatory training programme. At the time of the inspection, 90% of staff in the outpatient and diagnostic imaging department had completed the training. The use of audits provided the hospital senior management team with assurance about the infection prevention and control practice across the hospital.

- Bins for clinical waste, non-clinical waste and sharps were in all clinical rooms and waste in the outpatient department was properly stored, managed and disposed of.
- Since the last inspection the hospital changed how staff accessed the sluice room, this was only accessed by staff that had a swipe card with permissions. This meant that the room was always locked to prevent patients or members of the public from entering the room.
- Since the last inspection the carpeted consultation room had been changed to a wipe clean floor. This was so that the room could be used for any invasive procedures or tests.
- We noted that equipment had 'I am clean' stickers on them; this showed that a piece of equipment had been cleaned and was ready for use.
- Hand sanitisers were widely available throughout the Outpatient and Diagnostic Imaging departments, instructions on hand washing were displayed above sinks in all clinic rooms.
- Personal protective equipment, such as disposable gloves and aprons, were available in all the clinical rooms in the outpatient department to prevent spread of infections. At the time of inspection we observed a member of staff walking through the corridor with gloves on, when approached the staff member realised that this was not good practice and advised that they would be taken off and replaced with new ones.
- All clinical staff in the departments followed the 'arms bare below the elbow' guidance to allow thorough hand washing and reduce the risk of cross infection.
- Curtains in clinical areas had been changed within the last six months. This meant the risk of cross infection was reduced.

Environment and equipment

- There were six clinic rooms in the OPD, two of which housed couches for gynaecological procedures, a treatment room, a sluice, eye room for ophthalmic appointments and a large waiting room.
- The diagnostic and imaging department had one dexa room, one ultrasound room and an x-ray room. The waiting room was located directly outside the rooms; it also housed a changing room for patients to use.
- Resuscitation equipment was in date and located in the main corridor between OPD and diagnostic imaging. The resuscitation policy was placed on the trolley, which meant staff had access to it at all times. The resuscitation trolley checks were completed daily and all actions were updated. The defibrillator was placed on the resuscitation trolley; it had been serviced in June 2017 and was next scheduled for service in June 2018.
- Equipment was calibrated and tested to ensure it was safe for use; equipment we saw in the outpatient department was labelled with the next testing date. The diagnostic imaging department had contracts in place to manage and maintain imaging equipment. Maintenance folders were available on inspection; they contained a maintenance schedule and faults record.
- Personal protective equipment (PPE) was available for staff and patients in the diagnostic imaging department. We saw lead coats and gonad shields in the imaging department; they are used to reduce the risk to patients and staff from exposure to radiation.
- We saw that the x-ray rooms had dose meters to measure the level of radiation. Staff knew that these readings there were required to be completed regularly. Readings were documented so that they could be reviewed by the radiation protection adviser.
- To prevent staff or visitors from entering the room when an x-ray was taking place, all three rooms in the imaging department had signs outside where radiological exposures were taking place in line with Ionising Radiation (Medical Exposure) Regulations IR (ME) R 2000. This ensured visitors or staff could not accidentally enter a controlled area.
- Signs on the doors of all the rooms in the imaging department warned female patients of the risks of being exposed to radiation if they were pregnant or might be pregnant.

- Call bells were in all consulting rooms and the treatment room; staff felt assured that they had access to call bells in case a patient deteriorated or they needed to call for help in other circumstances.
- The ward carried out an environmental audit every six months to check that the surroundings were safe and complied with the standards set out by Ramsay. The department achieved a 98% compliance rate.

Medicines

- Access to medicines was restricted to authorised staff only, keys for secure cabinets were held by one of the nurses on duty. We saw key holder recording sheets in the nurses' room, all were signed and legible.
- Medicines in the outpatient department were stored in locked, secure cabinets in the minor procedures room. Medicines in the radiology room were also kept in secure cabinets in the x-ray, ultrasound and Dexa Scan rooms.
- Medicines in the Outpatients department were stored in a locked cabinet in the department. We reviewed a selection of drugs; they were all within the manufacturer's use by date. We saw that drugs were stock checked and the cupboard systematically organised. This made it easy for staff to locate the medication and help determine when stock was low.
- We reviewed all the medication in the radiology department, which were all within the manufacturer's use by date. However we found several discrepancies in the actual number of medicines in cupboards and the number written on the stock sheet. Medicines were unaccounted for and staff were unaware of where they were at the time of inspection. None of the medications missing were controlled drugs.
- The department manager had recently introduced stock control recording sheets; this was so that there was a clear trail of when medication was taken from the department. For example the Ramsay Diagnostic UK (RDUK) mobile van used the medications from the department and took a number of medicines each morning.This meant that stock reconciliation as not always clear. Concerns were escalated to senior managers who reviewed our findings and actioned them immediately. A risk assessment was carried out and a new tracking mechanism was introduced for all medicines that go to the Resource development UK mobile van. The inspection team left the site assured that the management team had put systems in place to minimise the risk.
- We checked fridges where medicines were kept if they required storage at a lower temperature. Fridges were locked, temperatures of the fridges and the ambient temperature of the room was checked and recorded daily. This meant that the service could be assured that the drugs were stored within the recommended temperatures advised by the pharmaceutical company.

Records

- We reviewed 10 sets of randomly selected OPD patient records of patients who had procedures. All records were complete, legible and signed.
- Records in the outpatient department were appropriately stored within lockable cabinets in the nurses' room, behind reception. The cabinet was kept locked when it was not in use. Records were collected by the administration staff and archived.
- An electronic system to store records, including images taken, was used by staff; this was a picture archiving and communication system (PACS).Information about imaging was stored on a separate electronic reporting information system (RIS).
- NHS patients had full medical records, consultants offering private consultations were responsible for creating and maintaining their own records of private consultations.
- A temporary medical record would be created if a patient attended and their hospital record was not available. Information about the previous hospital correspondence was saved electronically; this was printed out and added to the temporary medical record to inform the doctor of the previous treatment and to reduce any risk to the patient.

Safeguarding

- Ramsay Health Care UK group-wide policies for the safeguarding of vulnerable adults and children was used by staff in both departments. The policy outlined types of abuse and concerns about the welfare and safety of patient's which staff should escalate.

- The clinic did not provide services for patients under the age of 18 years and children, this decision had been made since the last inspection.
- All staff had access to a paper flowchart that illustrated the safeguarding process; this was also displayed in the nurse's office in the outpatient department.
- Training data showed that all staff in the Outpatient department including Diagnostic and Imaging radiographers and physiotherapists, were required to complete level two safeguarding adults training. Information provided by the hospital showed 100% of these staff had completed level two safeguarding adults training.
- There was a Regional Safeguarding Lead who covered the Northern Ramsay Hospitals. Staff sought advice from the lead if they had any concerns; the Regional Lead attended the Lancashire Safeguarding Adults Board - Leadership Sub-Group meeting quarterly. The Regional Lead also attended training and received updates from the local Safeguarding Board in Lancashire and Salford.
- All staff we spoke with in both departments had a good understanding of what should be reported as a safeguarding concern. Although a decision was made to stop treating children at the hospital in 2016, staff recognised that they should be aware of how to raise a safeguarding referral for children, because they may witness a child come to harm when accompanied adult patients.
- We saw 'pause and check' posters in the x-ray room, these posters reminded staff to check information about the patient. For example to check the patient's details, this was to avoid or reduce the risk of someone receiving the wrong image and unnecessary exposure to radiation.

Mandatory training

- Mandatory training was made available to all staff, some elements of the training was completed through E-learning which staff could access at a time to best suit their needs. E-learning was available during the working week or at home. Training completion dates for staff were set by head office, managers were sent a weekly report on staff training and this meant they could chase up staff that had not completed training.
- Mandatory training included modules such as fire training, moving and handling, safeguarding, PREVENT, infection prevention and control and consent.
- The hospital target for completing mandatory training was 100%. Information later provided by the hospital showed that not all staff had completed their statutory mandatory training modules. However, rates were still high with 90% of staff in the OPD completing Basic Life Support training.

Nurse staffing

- We reviewed the staffing levels in the Outpatient department; there was no set guidance for safe staffing levels. The staff rota was based on the number of clinics running each day. Staff told us, some days required more nursing and healthcare support than others because of the number of clinics and the case mix of patients.
- Department managers had allowed nursing and healthcare assistants to complete the rota. This was so that staff owned their workload and were responsible for the rota. All staff we spoke with found this helpful and told us it helped their work life balance. The department manager had overall oversight of the rota, skill mix and nurse numbers on each shift.
- Information provided by the hospital showed that on 30 June 2017, the outpatient department employed four whole time equivalent (WTE) nursing staff; this had increased since the last inspection by 0.6 WTE. The number of health care assistants (HCAs) had also increased since the last inspection from three WTE to five WTE. The department did not have any vacancies at the time of inspection. The radiology department employed 3.7 radiographers and one HCA at the time of inspection.
- The Outpatient department used 8% of agency and bank staff to cover shifts which were not covered by permanent staff. Radiology did not use agency staff, but reported using 13% of bank staff between the reporting periods of January 2017 – June 2017. This had increased since the last inspection.
- The hospital had an induction policy, which set out the mandatory training which all staff, including bank staff, had to complete before starting at the hospital or in exceptional circumstances within the first two weeks.

Good

Outpatients and diagnostic imaging

- The OPD department reported 11.5% sickness rate and radiology reported 1% sickness rate between January 2017 – June 2017, both departments had a 0% unfilled rate for the same reporting period. This meant that all shifts were correctly filled for that time period.

Medical staffing

- There were six radiologists that held practicing privileges at the hospital between January 2017 and June 2017.
- All consultants who practised under practicing privilege rights were expected to provide evidence of their experience and competencies to provide care and treatment to patients. This included annual appraisal documentation, personal indemnity cover and mandatory training compliance figures. We observed this through our reviews of personal files and discussions with staff.
- The hospital had a resident medical officer (RMO) on site 24 hours a day, who could provide medical support to the outpatient, diagnostic imaging and physiotherapy departments.

Emergency awareness and training

- The hospital business continuity plan listed key risks which could affect the provision of care and treatment. The plan was available on the intranet. At the time of inspection a paper copy was also filed in the nurse's office behind the reception desk.

Are outpatients and diagnostic imaging services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- Staff delivered care and treatment within the outpatient department and diagnostic imaging department in line with evidence-based practice. For example the diagnostic imaging department referred to national guidelines from the Royal College of Radiologists and the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 in its advice and procedure documents for staff.
- We saw a variety of Ramsay Health Care UK group-wide policies referring to national professional guidance and standards. The hospital's policies and protocols were standardised at corporate level. All policies were available online, they incorporated up to date recommendations and guidelines from the National Institute for Health and Care Excellence (NICE) and other professional bodies including the relevant Royal Colleges.
- All the departments we visited participated in regular audits, including, MRI referral hand hygiene, various infection prevention audits and compliance with IR (ME) R. These audits demonstrated overall good compliance.

Pain relief

- The pain service provided two types of injection treatments for back pain; injection into the weight bearing joints of the spine between two vertebrae and nerve block injections under x-ray guidance.
- In the outpatient department, consultants were able to provide prescriptions to patients who required pain relief. Some of the procedures in the department were carried out under local anaesthetic.

Patient outcomes

- The hospital carried out audits to assess and monitor patient outcomes. Radiology worked towards IR (ME) R and best practice guidance. A recent MRI audit showed 50% of referrals were completed on the wrong form, staff informed consultants of changes to forms and an action to re audit was documented.
- The diagnostic imaging department carried out imaging audits every three months, to check whether the department was carrying out images of the correct area, were following the correct protocol and if the image quality was correct.

Competent staff

- All staff were knowledgeable and had the experience to deliver effective care and treatment. Staff felt confident in caring for patients and were familiar with the requirements of their role.
- Staff felt they were supported in developing new skills to better them in their role. The hospital had a continuing professional development (CPD) policy in place; all staff were encouraged to maintain an up to date CPD file. The

manager of the OPD department manager told us that funding existed for formal learning activities within the corporate and local training budgets and through the Ramsay Health Care UK Scholarship Fund. All staff were aware of this and informed us that they could request training through the Ramsay Health Care UK Academy Prospectus.

- All staff that required professional registration within the radiology department were registered with the Healthcare Professionals Council (HCPC).
- New staff were required to undertake an induction training programme. A competency framework was in place and staff were expected to follow and complete this. The hospital operated a buddy system to support new starters through their induction. Managers used a Ramsay Health Care UK group-wide induction policy, which set out the induction process.
- To facilitate induction, new staff were given an induction handbook and a checklist; this was completed with their manager. At the time of the inspection there were no new starters and therefore we could not speak to any, but all staff we spoke with were willing to support.
- Training records for all staff were held at the hospital, staff in the radiology department had appropriate training to administer radiation. No untrained staff were employed.
- The radiology department held competency records, these included competency to use each piece of equipment within the radiology treatment rooms and the movement of equipment within the rooms. Staff also attended a radiation protection update training course every two years.
- Consultants worked at the hospital on a practicing privileges basis, they were always interviewed by the general manager and the matron. All consultant practicing privileges were reviewed by the medical advisory committee before being confirmed by the Ramsay health care UK medical director. Consultants were asked to provide copies of their training and General Medical Council's specialist register certificates, identification, disclosure and barring service, review of references and evidence of indemnity insurance.This information was signed off by the general manager.
- Not all staff had received an appraisal; staff appraisals were carried out yearly between January and June 2017and 67% of nursing and 100% healthcare staff in the OPD had received an appraisal and all staff in radiology had received an appraisal. Appraisals were used to discuss objectives and continuing development plans.

Multidisciplinary working

- There were limited opportunities for the staff to take part in multidisciplinary working; this was because of the nature of the OPD and diagnostic imaging clinics. Staff worked as a team across the physiotherapy, OPD and diagnostic imaging department. This meant that staff were able to discuss and understand what the best care for the patient was according to the patient's lifestyle.
- The radiology manager was meticulous in making sure that there was a justification to why a patient was being referred for radiology by consultants. This was so that exposure to radiation for radiology images was kept to a minimal.
- Images were available to referring clinicians through the hospital's system. This meant that plain X rays were available to view after the image was taken. The radiologist subsequently prepared the formal report, but if there were any concerning images indicating an abnormal result, initial findings would be reported to the clinician. The GP was also made aware of an abnormal result within 48 hours.
- Letters were routinely sent to the patients' GPs; we saw evidence of this in the medical records we reviewed. The diagnostic imaging department told us it shared results with patients' GPs and planned to audit this.

Seven day service

- The outpatient and diagnostic imaging departments did not offer a seven day service. They offered a five day service Monday to Friday from 8am to 8pm. It also opened on Saturdays between 9am and 2pm if there were patients listed for ultrasound procedures.

Access to information

Good

Outpatients and diagnostic imaging

- At the time of inspection patient records were securely transported from the OPD to medical records office each morning and afternoon. Patient records on the day of clinic were stored in a locked cupboard in the nurses' room behind reception until they were needed.
- Staff including consultants were not permitted to remove records from the hospital. This meant that staff had access to clinical and non-clinical information at all times, so effective care and treatment could be delivered to patients.
- All images in the imaging department were stored on an electronic picture archiving and communication system (PACS), this was accessible by radiographers and consultants with practicing privileges.
- Staff in the imaging department had access to an image exchange portal, this meant that the service was able to access and share images securely with NHS or other independent hospitals.
- Discharge letters were sent to the patient's General Practitioner (GP) following completion of treatment. This was so that the GP was informed of any clinical information, such as changes in medication or results from diagnostic results.
- We reviewed a variety of printed copies of policies and procedures and meeting minutes, these were all readily available in staff areas of each of the departments. If polices or protocols were updated or changed, staff were asked to sign documents to verify they had read new information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of inspection, all clinical staff had completed E-learning on factual information on dementia as part of their mandatory training, which covered consent and the Mental Capacity Act (2005). Staff we spoke with were aware of the Mental Capacity Act and the importance of consenting a patient, but their level of knowledge and understanding varied.
- Training records confirmed that all staff at the time of inspection all were trained in consent. The hospital used a Ramsay Health Care UK group wide consent policy, which we reviewed onsite, this addressed situations where patients lacked the ability to give consent.
- In the imaging department, written consent was taken by radiologists for any interventional procedures. Staff would also obtain verbal consent at different stages of treatment to assure the patient was still comfortable with the treatment carried out.
- Consent was taken in two stages, stage one was carried out by the consultant in the outpatient clinic during the consultation. This included a discussion about the risks and benefits of the chosen treatment. The second stage of consent was carried out on the day of treatment, this included confirmation that the patient understood the risks of the treatment and that they were happy to proceed with the chosen treatment.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- Staff treated patients in the outpatient and diagnostic imaging services with dignity, respect and compassion. Whilst on inspection, we observed staff politely addressing patients when talking to them. All staff in the OPD department had attended customer care excellence and good communication and person centred training. This was part of mandatory training and was delivered to staff so that understood the importance of delivering compassionate care.
- Patient satisfaction survey data was reported for the hospital as an overall percentage because the response rate was low. For the period between January and June 2017, the hospital received 15 responses; all patients said they were satisfied with the care they received from nursing, radiology and medical staff.
- We spoke with eight patients during our visit; all patients spoke positively about the staff and the care provided to them, three patients told us they had visited the department previously and said that staff were also polite and friendly.
- A chaperone service was available to patients. Staff asked patients if they required a chaperone if they had a requirement for one.

Good

Outpatients and diagnostic imaging

- Consulting rooms has curtains around examination couches or beds; we observed that doors were closed during consultations to maintain privacy.
- Four patients did have concerns about the time they had been waiting, but told us 'staff kept them informed and were very helpful'.
- One patient who attended for X-ray was greeted by staff; however the member of staff did not introduce themselves by name.
- There were no separate male and female changing rooms with lockable cubicles and lockers for patients changing into gowns for scans in the radiology department. We also noted that patients had to walk through the waiting room in a gown to enter the scan areas. This compromised patients' privacy and dignity.
- The OPD reception area was open and faced the main waiting area, therefore any sensitive in conversations could be overheard and we did not observe any confidential information being discussed at the reception desk at the time of inspection.

Understanding and involvement of patients and those close to them

- All patients told us, they had been involved with decisions about their care and had been actively involved in the care plan. Patients said they had received good information about their condition and treatment prior to their appointment.
- Clinic opening times were over 12 hours, six days a week, which allowed patients to come at a time most convenient to them. It also allowed relatives or friends to attend so that they could support the patient.Three patients told us that follow up appointments had been made quickly and within a reasonable timescale.
- Through observations, we saw that staff prepared patients for their treatment by communicating the next steps to them.Staff were attentive and took a personal approach to caring for their patients. They explained the treatment to be undertaken, and information relating to aftercare.

Emotional support

- On the day of inspection, the clinic was very busy; from our observations we saw that staff were attentive.
- We did not see a range of patient information leaflets to give to patients, explaining the patient's condition and treatment. These were not provided during consultations and meant that patients were not able to consider their options at home before making any decisions to proceed.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- There was a wide range of outpatient clinics offered around 16 specialities.
- Outpatient clinics were provided to people over the age of 18 years old.
- Rooms for consultants who had regularly weekly clinics in the hospital were scheduled in by staff on the Outpatients department. The hospital was able to add in adhoc clinics for consultants on an impromptus basis. Staff told us they would always endeavour to work with the patient and consultant to arrange an appointment at the next available slot.
- Any issues relating to over utilisation of appointment slots were discussed with individual consultants. The hospital could adjust the number of appointments available to meet the demands of its services. At the time of inspection the appointment slots were not monitored but staff told us that clinics often ran over. To overcome this, managers were looking to introduce additional mop up clinics.
- At the time of our last inspection, commissioners were not given full oversight of hospital performance. However, the new senior management team were currently engaging with the clinical commission groups to scope the direction of their commissioning contracts.
- The waiting room was clean and comfortable with adequate seating and a television. Toilets were close and reading material was available in the reception area.

Good

Outpatients and diagnostic imaging

- There was a water dispenser in all the waiting areas and a hot drinks machine in the Outpatient department.
- Patients had access to free car parking on-site. The car park was small and could easily reach full capacity on clinic days. However, the hospital had good local public transport links for those using public transport.
- Clear signage was seen throughout the hospital to guide patients to the relevant Outpatient, radiology and physiotherapy departments. The reception staff directed patients to the appropriate waiting areas.
- The Outpatients and diagnostic imaging department provided a six-day clinic service (the department was not opened Sundays), which included evening clinics up to 9pm. This was so that they could provide flexibility for patients who worked and could not get to the clinic during the day. However, there was less flexibility for outpatient appointments because these depended on the speciality or consultant a patient needed to see.
- The diagnostic imaging department had a cubicle situated in the waiting room for patients to use to change before a scan or procedure. This meant patients had to pass other patients with a gown on once they had changed.

Access and flow

- Patients were referred into the OPD service directly from GPs, consultants and through the NHS choose and book appointment system. Patients could self-refer into the physiotherapy service for priority appointments.
- Patient referrals to the OPD service for NHS patients were made through the “choose and book” system. Patients described the experience as ‘very timely from beginning to end’.
- OPD patients started treatment within 18 weeks of being referred; data provided by the hospital showed 99% of admitted and non-admitted patients received treatment within 18 weeks.
- The provider consistently met the national standard of 92% of incomplete pathways patients beginning treatment with 18 weeks of referral.
- Information provided by the hospital confirmed that from 1 July 2017, no patient waited longer than six weeks for magnetic resonance imaging scanning (MRI), computerised tomography CT, non-obstetric ultrasound, colonoscopy, flexible sigmoidoscopy and gastroscopy OPD diagnostic investigations.
- Patients we spoke with in all areas told us that tests, examinations, and follow-up appointments were scheduled quickly and that staff were responsive.
- Missed appointments were followed up with a letter to the patient requesting they re-book the appointment. If three consecutive appointments were missed, the consultant informed the patient’s GP and a new referral was then required.
- The Outpatient department used an electronic system to schedule clinics and track patients from when they had arrived in the hospital. Staff were able to monitor clinics to see whether they were running on time.
- Staff were aware of lengthy consultations and monitored clinic start and finish times. The department manager used this data to monitor the performance of consultants. For example consultants who always had delayed clinics were asked to review their caseload to ensure patients were seen on time.
- Staff in the diagnostic imaging department told us they reported images within 24 hours for inpatients and images within one week for Outpatients.
- Clinics did not run to time during our visit to the hospital and waiting times for patients after booking in at reception were lengthy. Staff were aware that some clinics ran later than others. Staff told us that if a clinic was running behind, they would apologise to patients waiting for that clinic and keep them updated about the progress of the clinic. Patients were also given the opportunity to rebook if the wait was too long.
- The hospital did not audit the waiting times for attending a clinic, timing of clinics or cancellation of clinics. Staff told us that there were always delays, but because this information was not collected, the hospital could not give assurances of the timeliness of clinics. Since the inspection the hospital management team have advised us that they are now monitoring the time patients are waiting in the waiting room.
- We did not see any notices in the outpatient waiting area that told patients to speak to the reception desk if their appointment was delayed by 10 to 15 minutes.
- Patients were not offered food if clinics were delayed for a long time.

Meeting people’s individual needs

- The hospital used a translation service, providing face to face and a telephone based translation services. Staff and patients had access to these services through Language Line.

Good

Outpatients and diagnostic imaging

- Entrances to the hospital were accessible for people with mobility problems. The Outpatients and diagnostic imaging department were located on the upper floor and were accessible by a lift.
- Due to the nature of the services provided within the Outpatients and diagnostic imaging departments, staff told us they did not have large numbers of patients with learning disabilities or people living with dementia. Staff were unsure how they would accommodate a patient with learning disabilities if they attended the clinic. However, managers of the service informed us that staff would be encouraged to involve carers and relatives in the consultations. Large print and easy read information was available
- The hospital ensured the toilet facilities within the Outpatients department were disabled friendly, improved access for people with mobility issues at the entrance to the hospital and parking facilities. Data from the PLACE audit showed that patients visiting the hospital were overall happy with facilities.
- Information leaflets about services and treatments were not readily available in all areas.
- Managers of the department told us they could provide leaflets in different languages or other formats, such as braille. However, staff were unsure where they were stored when asked to locate them.

Learning from complaints and concerns

- The hospital had a complaints policy; this was available to staff online and in paper form. The hospital aimed to acknowledge all complaints within 24 hours and to provide a full response within 20 working days.
- The OPD and radiology department reported no complaints between the reporting period of January 2017 and June 2017.
- All staff we spoke with understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Staff told us they always attempted to resolve patient concerns verbally at the time they were raised.
- We spoke to three returning patients who told us they knew how to make a complaint should they wish to. Leaflets detailing how to make a complaint were readily available in all areas. However, we did not see any posters displayed around the hospital detailing how to make a complaint.
- The hospital recorded complaints on the hospital-wide system. The department manager and matrons were responsible for investigating complaints in their areas.
- Complaints were discussed at a range of governance meetings, including the heads of department meeting and the medical advisory committee meeting. Ramsay health care UK organisation used complaints to learn and improve their hospitals; complaints were shared with all at a corporate level.
- At a local departmental level, complaints appeared on the team meeting agenda to facilitate learning. Senior managers within the service told us information and key lessons learned from complaints were always discussed and this was evident in minutes of meetings we reviewed.
- If complainants were not happy with the outcome or the complaints process, they had the right to take their complaint to the Health Service Ombudsman (for NHS patients) or to the Independent Sector Complaint Adjudications service (ISCAS – for patients who were self -funding).
- At the time of the inspection, none of the patients we spoke with expressed any concerns or complaints about the care they had received from staff in the department.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership and culture of service

- Staff felt there was a good working relationship with the matron, she was visible across all departments and communication with the corporate central communications team had improved immensely. Whilst on inspection, we observed astounding leadership from the corporate team, hospital senior management team and the heads of department. Staff spoke positively about the overall leadership team and told us that this had vastly improved since the last inspection.
- The OPD manager had moved to a different area so that a more focused approach could be taken to streamline

process on the ward and day care service. Staff in the outpatients department told us that the previous head of department was very responsive to staff concerns; they openly discussed and addressed issues.

- Change in management had unsettled staff we spoke with; the new manager was not as visible, but staff understood more time was needed to embed relationships and ways of working.
- Managers championed staff development and flexible working amongst the team; this created a positive working environment that staff appreciated. All staff from managers to the receptionist were given the opportunities for development and training through the Ramsay health care UK Academy.
- Staff in all departments told us that staff morale had improved since the last inspection and leadership was better. They informed the inspection team, they was no longer fearful of management and felt confident about speaking out to their line managers or the senior management team.
- We spoke with a number of staff who all felt respected and liked coming to work. Staff commented on the cultural change they had experienced since the last inspection, they enjoyed working in an open and honest culture. Data provided by the hospital for the reporting period of January 2017 – June 2017, reported 84% of staff felt a strong sense of belonging to their workplace; this had increased since 2016 (63%).

Vision and strategy for this core service

- The management team used the corporate strategy and vision called the 'Ramsay Way' to set out behaviours and values expected of staff working for the organisation.
- Staff working at departmental level we spoke with in all areas had a poor knowledge of Ramsay Health Care UK's and the hospital's vision and strategy. None of the staff we asked mentioned the 'Ramsay Way' or the clinical strategy. However senior staff were aware of this strategy and vision.
- Both the corporate and clinical strategy was supported by the 'six c's of nursing' (care, compassion, competence, communication, courage and commitment). We noted that some areas displayed these posters, but posters were small and not always visible.
- The Department manager was passionate about how they wanted their department to grow. They discussed how they would improve the service operationally, but failed to a give explanation on how this would be aligned in the overall arching hospital strategy.
- Since the last inspection, the outpatients manager had implemented had increase outpatient clinics services, such as ophthalmology. The department were still working towards plans to build a soundproof room, which could be used for audiology appointments.

Governance, risk management and quality measurement

- The robust governance framework in the hospital supported staff to deliver good quality care in the department. As part of the wider corporate organisation, the hospital had a clear governance and committee structure in place including clinical governance, medical advisory and health and safety committees.
- The committees were well represented with non-clinical and clinical attendance, this allowed for good oversight of both clinical and operational review.
- The department manager was clear about the roles and responsibilities and how they fitted within the hospital governance structure. Discussions confirmed that they were involved in the decision making.
- Regular monthly senior management meetings were held, we reviewed a selection of minutes from these meetings, and agendas included reviewing corporate policies and guidelines, complaints, significant events and lessons learned.
- All heads of departments across the hospital attended the quarterly clinical governance meeting. Standing agenda items discussed included: review of key clinical indicators, corporate audits, patient complaints, adverse incidents, risks and infection control. A three monthly report was also produced containing a summary of key performance indicators, serious incidents, patient satisfaction surveys and new updated guidance and audits.
- A cooperate programme of audits was in place across the outpatient and diagnostic imaging departments. At the time of the inspection the audit programme was monitored by the clinical effectiveness lead and monthly performance was updated.
- A risk assessment policy was in place and all risk assessments were carried out by the senior manager. The policy detailed responsibilities for each member of

staff and actions to be taken to assess risk and to record and score risk assessments. At the time of inspection, the department had 31 risk assessments; risks were scored by the severity and likelihood of it occurring; once assessed they were given a risk score. Each of the risks was reviewed yearly. All assessments reviewed were signed and stored appropriately, so that staff had access to the documentation.

- There was a corporate risk register that was reviewed by the senior team. This listed ongoing risks to Oakland's hospital, as well as other hospital sites across Ramsay. However, of the five members of staff who we spoke with at the time of inspection, nobody knew about or could locate a hospital or departmental risk register. Staff told us that staffing was a risk to the department and not having a receptionist on the desk after 4pm was also a concern. When we spoke to staff only one member of the team was aware of what local actions had been carried out to mitigate the reception desk risk. This meant there were no assurances that senior staff shared current risks with departmental staff, which meant they were unable to suggest ideas to help mitigate risks appropriately.
- Medical advisory committee (MAC) meetings were held bimonthly. All meetings followed standing agenda items, including: review of the general hospital update, review of the clinical governance report and complaint, sign-off for use of any unlicensed medication and credentialing of new consultants. Arrangements with the MAC were in place for checking and confirming consultants' indemnity insurance in line with legislation, qualifications and registrations.
- The departments held their own team meetings; the department manager used the meeting to feedback any information from hospital-wide meetings. We reviewed minutes of the May 2017 OPD meeting; it followed a standard format and was emailed to staff after the meeting.
- The Ramsay Healthcare UK group held a radiation protection committee with regional representatives. Staff in the radiology department were happy to escalate issues to the radiation protection committee through the regional representative.
- We saw evidence in the minutes that complaints were reviewed and discussed at the hospital's clinical governance committee, medical advisory committee and senior nurses meetings to share findings, trends and learning with service leads and consultants. In the May 2017 meeting, it was evident that managers used the platform to share learning from complaints.
- A review of the audit programme revealed there were no action plans to show updates and progress of audits.
- Where we found low compliance, there was no documentation to support if action had been taken by heads of department. For example where the clinical effectiveness lead had emailed heads of department to chase audit results or low compliance, we were unable to locate returned communication that showed this had been escalated or disseminated to staff to improve compliance rates.
- The hospital reviewed serious incident on a tracker; this was to ensure appropriate investigations took place and that further learning and to improvements could be. At the time of the inspection there were 19 open serious incidents dating from 2015. However, seven from 2016 had not been investigated or looked at. Furthermore two from 2017 were open, but no investigation had taken place.

Public and staff engagement

- Staff were asked to complete an annual staff survey, so that the hospital could ascertain feedback. The hospital survey was called 'my voice survey'. For the purpose of the inspection, the hospital provided data for the reporting period of January 2017 – June 2017; 81% of staff said they were motivated by the company to do the best job they could do. This had significantly increased since 2016.
- The survey also demonstrated that staff were happier in the work place; 91% of staff said they would recommend the hospital to friends and family who need care. This meant staff working at the hospital were confident in their peers and the service they delivered; this had improved since 2016 survey.
- The hospital gathered feedback from patients in a number of ways; this was so that they could improve patient care and experience. The 'we value your opinion' leaflet (which also provided details of how to complain) was available in the OPD and radiology waiting rooms for patients to complete. The hospital also gathered feedback using the hospital's patient satisfaction survey and the NHS friends and family test (which asks patients to rate how likely they would be to recommend the service to their friends and family).

Good

Outpatients and diagnostic imaging

- Patient satisfaction was not currently collected by individual services; this was because the number of responses would be too low to maintain patient anonymity. The hospital sought feedback once patients had been discharged. The feedback was based on the hospital as a whole; between January 2017 and June 2017, the hospital reported a 35.5% survey response rate. The received 15 responses which gave them a patient response rate of 1.1%. The hospital reported 80% of patients who attended the hospital between January 2017and June 2017 would recommend the hospital to friends and family if they needed similar care or treatment. All patients said they were satisfied with the following aspects of their care: the nurses, the doctors and the radiographer. However, of the 15 responses received, 30% of patients were dissatisfied with the aftercare they received, 43% of patients were not told who to contact if they were worried about their condition or treatment after leaving hospital and 44% of patients said staff did not tell them about medication side effects to watch for when they went home.
- We reviewed positive comments that had been left on the NHS Choices website by patients. Comments left in June and July 2017 were positive and complimentary of the staff in the OPD department.
- The hospital organised events for staff to attend outside of working hours, this was so staff could socialise and form relationships outside of work. The hospital combined and optimised the way they engaged with their staff engagement and the public. For example they had organised a quiz night on 1 June 2017 for staff, all prizes were donated by the Oakland's Hospital and all proceeds were given to the Alzheimer's Research UK.
- The hospital had a disclosure of information (whistle-blower) policy. This was available on the staff intranet and set out the procedures to follow with internal disclosures and with disclosures to regulatory bodies.
- In the May 2017 clinical governance meeting, the matron shared with the committee the results of the recent hospital walk round and results of interactions with patients. Overall it was reported that responses were positive, however this was for the whole hospital and was not specific to OPD or diagnostic and imaging. Team meeting minutes for May 2017 showed OPD and diagnostic and imaging department did not receive any patient satisfaction survey feedback.

Innovation, improvement and sustainability

- To improve the way Ramsay collect patient feedback, currently a patient experience review was underway and as part of this consultation a new patient experience strategy will be developed. This strategy will aim to address the lack of feedback to individual services.
- Senior managers worked with consultants to provide innovative ways to engage with the local population, for example on 14 August 2017, the hospital were holding a patient participation group meeting. The meeting was titled "how to look after your joints". The aim of the meeting was to provide a platform for patients to learn and ask the orthopaedic consultant questions about their caring for their joints.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that all staff complete the relevant mandatory training for their roles.
- The hospital must ensure that controlled drugs and medications are managed safely and correctly in line with legislation, local and national guidelines.
- The hospital should ensure that all areas are clean and free from soiling.
- The hospital must ensure that patient risk assessments and pre-operative anaesthetic assessments are completed and documented correctly.
- The hospital must ensure all measures designed to assess and mitigate risks to patients are adhered to. For example adherence to the WHO process and checks.
- The hospital must ensure that it maintains a complete, accurate and contemporaneous record of patient care and treatment

Action the provider SHOULD take to improve

- The hospital should monitor how long patients are waiting in clinics to be seen.
- All staff should receive an annual appraisal
- The hospital should ensure that all staff are aware of what constitutes a reportable incident.
- The hospital should ensure that all staff have a high and working level of knowledge in relation to the Mental Capacity Act.
- The hospital should consider the arrangements for patients to change in the radiology department.
- The hospital should ensure that information leaflets about services and treatments are readily available in all areas.
- The hospital should review their serious incident tracker and ensure this reflects the investigation stages that have been undertaken.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines at all times. Not all staff had the required level of training. In some cases risks assessments were not completed and risks were not mitigated. For example adherence to the WHO process and checks Infection control measures and precautions were not always maintained and followed Regulation 12 (1) (2) (a, b, c, g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain a contemporaneous, accurate and complete record for all service users. Regulation 17(1) (2) (c)