Ramsay Health Care UK Operations Limited

Boston West Hospital

Quality Report

West Business Park
Sleaford Road
Boston
PE21 8EG
Tel:01205 591860
Website:www.bostonwesthospital.co.uk

Date of inspection visit: 28/29 April 2015 and 14 May 2015
Date of publication: 23/10/2015

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Boston West Hospital is an independent health care, purpose built day case hospital which provides services for assessment, diagnosis and treatment of common medical conditions. The hospital is part of the Ramsay Health Care provider group.

The hospital's senior management team consisted of a registered manager, matron and medical director who provided professional leadership for all staff. The chair of the hospital's local Medical Advisory Committee (MAC) was a member of the provider's regional MAC.

We inspected the hospital on 28 and 29 April 2015 on an announced visit. On 14 May 2015 we carried out an unannounced inspection of the hospital.

We inspected surgery and outpatients and diagnostic imaging at Boston West Hospital. Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections.

The overall rating for the hospital was good. We found Surgery services were good in all of the five domains we inspected; Safe, Effective, Caring, Responsive and Well-led. Outpatients and Diagnostic Imaging services were good in the four domains we inspected; Safe, Caring, Responsive and Well-led.

Are services safe at this hospital?
We found a robust incident reporting system in place at this hospital. Staff knew how to report incidents and were encouraged to do so by their managers. Staff monitored patients before, during and after their procedures and surgery to minimise risks to individual patients. Nursing and surgical staffing were managed effectively to deliver appropriate care to patients.

Are services effective at this hospital?
Evidence based assessment, care and treatment was delivered to patients following national guidance by appropriately qualified and competent staff. Clinical staff maintained professional registrations as required. We found clinical staff had completed mandatory training and had all received annual appraisals. The hospital had an audit programme in place for 2014/15 which included audits of medical records, controlled drugs and medicines management and infection prevention and control. Medical records audit in January 2015 showed 98% compliance. Audits in controlled drugs and medicines management showed 100% compliance in December 2014 and October 2014 respectively. A hand hygiene audit in December 2014 showed 94% compliance.

Are services caring at this hospital?
The care we observed in the hospital was very good. Staff were very attentive and compassionate, with patients being involved at every stage of their treatment. Staff were very proud of the care they delivered and spoke about patients with utmost respect. Patient satisfaction was high with recent data showing that over 90% of outpatients and patients undergoing surgery would recommend the hospital to their family and friends as a place to receive treatment and care.

Are services responsive at this hospital?
We saw the care delivered was very responsive to patients' needs. The hospital had measures in place to support patient's differing needs, such as access to interpreters via a telephone interpretation service. The hospital had trained two members of staff to work as dementia champions so they could advise other staff on how best to support people living with dementia. Between October 2014 and February 2015, 100% of patients were seen within the 18 week referral to treatment target. In 2014 the hospital received 10 complaints. We found complaints were taken seriously, with processes in place to learn from them and share this learning with staff.

Summary of findings

Are services well-led at this hospital?

The hospital had a robust governance and risk management system in place. Morale was good with staff talking positively about the organisation and their local management team. Engagement at all levels was good with staff feeling listened to and supported. Feedback from patients was encouraged and when feedback rates had dropped, initiatives were put in place to increase it.

Our key findings were as follows:

- All clinical areas were clean. The hospital had reported no incidence of MRSA, clostridium difficile (C.diff.) or methicillin-sensitive staphylococcus aureus (MSSA) in the reporting period between January to December 2014.
- Best practice infection prevention and control practices were being followed.
- Nursing staffing was managed effectively to ensure patients received safe care with access to consultants obtained in a timely manner. Staffing levels were reviewed daily to enable team leaders in the clinical areas to flex their staffing, according to patient requirements. The hospital had not used any agency staff for the twelve months prior to our visit.
- The provider employed 1.6 whole time equivalent (WTE) consultants in the hospital; an anaesthetist and a surgeon. At least one of the employed consultants was present throughout the hospital's operating hours. A consultant anaesthetist was present in the hospital for both operating lists each day. This meant they could respond quickly in an emergency and reduce any risk to patients.
- The hospital had not reported any patient deaths between January 2014 and December 2014. There had been no transfer of care to a nearby trust for patients between January 2014 and December 2014.
- Staff followed guidance on fasting prior to surgery which was based on best practice. For healthy patients requiring a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- The hospital provided only day surgery, therefore meals were not provided. A selection of hot drinks and biscuits were available to patients once they had recovered from their procedure and prior to discharge.

We saw several areas of outstanding practice including:

- 100% of staff had completed all mandatory training and appraisals in 2014/15.
- The hospital had been awarded accreditation by the Joint Advisory Group (JAG) on gastrointestinal endoscopy and was the first independent hospital to achieve this.
- The hospital operated a 24 hour telephone helpline run by hospital staff, available to all patients post procedure or operation.

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

Importantly, the hospital should:

- The provider should ensure specialist personal protective equipment (PPE) in radiology, including lead aprons, is checked regularly.
- The provider should ensure requests to repair equipment are made, recorded and completed using standard processes and procedures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good 	Staff demonstrated a good awareness of the process for identifying and recording any safety incidents. Arrangements were in place to minimise risks to patients before and after their procedure. Staffing was managed effectively to ensure patients received safe care with access to consultants obtained in a timely manner. Staff had undertaken all mandatory training. Records were kept securely and we saw they were accurate, up to date and legible. Evidence based assessment, care and treatment was delivered to patients following national guidance by appropriately qualified and competent staff. Patients received pain relief appropriate to their needs in a timely manner. Outcomes for patients were monitored on an on-going basis and either met or exceeded the provider's expected targets. A multi-disciplinary team approach was in evidence and we observed this throughout our inspection. The percentage of patients who would recommend the hospital for day case surgery varied between 94% and 97%. The care we observed in the hospital was very good. Patients were not rushed and were treated as individuals. Staff were very attentive and compassionate, with patients being involved at every stage of their treatment. Staff were very proud of the care they delivered and spoke about patients with utmost respect. We saw the care delivered was very responsive to patients' needs. Access to care and treatment was monitored and exceeded the national average. The hospital had a robust governance system in place. Morale was good with staff talking positively about the organisation and their local management team. Engagement at all levels was good with staff feeling listened to and supported.
Outpatients and diagnostic imaging	Good 	Overall the outpatients and diagnostic imaging service at the hospital was rated as good. We found that appropriate systems to respond to and learn from incidents were in place, as were systems to help protect people from harm or abuse.

Summary of findings

The hospital had access to a radiation protection supervisor and radiation protection adviser in accordance with the ionising radiation (medical exposure) regulations and had practices and systems in place in accordance with the legislation.
Patients spoke highly of the care they received and felt involved in and understood their care and treatment. Support was given to patients; both in the out-patient department and via a 24 hour telephone helpline run by hospital staff. Patient satisfaction was high with recent data showing that 90% of outpatients would recommend the hospital to their family and friends as a place to receive treatment and care.
Systems were in place to ensure staff were appropriately qualified to deliver care and treatment. Staff reported that management was supportive and they had access to a wide range of training opportunities to help develop their skills further.
The hospital management encouraged feedback from both patients and staff. Feedback helped inform changes to improve the service. Complaints were taken seriously with processes in place to learn from them and share this learning with staff.

Boston West Hospital

Detailed findings

Services we looked at

Surgery; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Boston West Hospital

Boston West Hospital is an independent health care, purpose built day case hospital which provides services for assessment, diagnosis and treatment of common surgical conditions. The hospital does not provide overnight care to patients.

Clinical facilities include a main reception, outpatient suite with five consulting/examination/treatment rooms and pre-operative assessment area. The hospital also has counselling facilities. The hospital has one theatre, where a range of surgical procedures and endoscopic (diagnostic) investigations are performed. Post-surgery, patients are transferred to a postoperative recovery room. A three stage Theatre Sterile Services Unit is located at the hospital and provides sterilisation services to the hospital and other locations.

Treatments available at the hospital include endoscopy, colonoscopy, hernia surgery, knee arthroscopy, shoulder arthroscopy, cataract surgery, cystoscopy, hand surgery, foot surgery, minor urology treatments, minor gynaecological treatments, vasectomy, varicose vein surgery, pain management, orthopaedics, and minor skin procedures. Diagnostic imaging is available at the hospital using a portable c-arm x-ray machine.

The hospital provides care and treatment for adults over the age of 18 for NHS, self-funding and insured patients. The majority of patients seen in the service were funded by the NHS using GP patient referrals through 'Choose and Book.' Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first out-patient appointment in a hospital or clinic.

The hospital delivers day care surgery, assessments and treatments to the residents of Lincolnshire and surrounding areas.

We inspected surgery and outpatients and diagnostic imaging at Boston West Hospital. Our inspection was part of our ongoing programme of comprehensive Independent Health Care inspections.

Our inspection team

Our inspection team was led by:

Inspection Manager: Yin Naing, Care Quality Commission

The team included CQC inspection managers, an inspector and a variety of specialist advisors, including an anaesthetist, an oral-maxillofacial surgeon and governance and operational management specialist.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the hospital.

Detailed findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about Boston West Hospital and asked other organisations to share what they knew. We carried out an announced visit between 28 and 29 April 2015.

During the visit we talked with staff and people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. The people who use services shared their views and experiences of the hospital with us. We carried out an unannounced visit on 14 May 2015.

We spoke with 15 staff including nurses, consultants, anaesthetists and supporting staff. We also held discussions with senior managers. A registered manager is in post for the hospital and had been registered for four years when we inspected.

For Surgery, we spoke with 11 patients and two accompanying relatives. For Outpatients and Diagnostic Imaging, we spoke with four patients. We also reviewed 13 sets of patient notes.

Facts and data about Boston West Hospital

Boston West Hospital was established in 2005. In 2010 the hospital provided care and treatment for patients over 18 years via NHS referrals through the 'Choose and Book' system via their GP. The hospital also commenced a service to self-funding and insured patients.

In 2014, 3,298 patients underwent surgery at the hospital. Of this number, 93 were self funding patients.

Between January and December 2014, a total of 3,582 outpatients were seen for a first visit and 6,856 outpatients were seen for a follow-up visit.

Of the total numbers of outpatients 3,493 NHS outpatients were seen for a first visit and 6,735 NHS outpatients were seen for follow up visits at the hospital.

In the same time period, 89 non-NHS patients were seen for a first visit and 121 non-NHS patients were seen for a follow-up visit.

The hospital is open 8am to 7pm, Monday to Saturday dependent on activity.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Surgery

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

Information about the service

Boston West Hospital is a small purpose built unit providing day surgery for adults over the age of 18 for both NHS and private patients undergoing a variety of procedures. These included general surgery, urology, gynaecology, endoscopy, colonoscopy, orthopaedics, ophthalmology and pain management. The majority of patients seen in the service were funded by the NHS using GP patient referrals through 'Choose and Book.' Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first out-patient appointment in a hospital or clinic. Services for surgical patients were provided in the outpatient's consultation sessions and the day surgery area. Facilities included one admission room and two pre-operative bays. Patients recovering from surgery were cared for in one of six areas dependent upon care needs. The hospital was open for six days a week between 8am and 7pm. It did not provide overnight facilities.

Summary of findings

The hospital had systems in place to keep patients safe. Processes were in place to report any incidents. Investigations were robust and staff learned from actions taken as a result. Staff demonstrated a good awareness of the process for identifying and recording any safety incidents.

Arrangements were in place to minimise risks to patients before and after their procedure. Staffing was managed effectively to ensure patients received safe care with access to consultants obtained in a timely manner. All clinical areas were clean and best practice infection prevention and control practices were being followed. Equipment was checked regularly and medicines were stored and administered safely.

Staff had undertaken all mandatory training and were aware of the actions to take in order to safeguard patients. Records were kept securely and we saw they were accurate, up to date and legible.

Evidence based assessment, care and treatment was delivered to patients following national guidance by appropriately qualified and competent staff. Patients received pain relief appropriate to their needs in a timely manner. Outcomes for patients were monitored on an on-going basis and either met or exceeded the provider's expected targets.

A multi-disciplinary team approach was in evidence and we observed this throughout our inspection. The

Surgery

hospital provided a six day per week service with senior nursing staff providing a 24 hour telephone service to discharged patients in case of concerns. Patients had good access to information.

The care we observed in the hospital was very good. Patients were not rushed and were treated as individuals. Staff were very attentive and compassionate, with patients being involved at every stage of their treatment. Between January 2015 and March 2015 the percentage of patients who were extremely likely to recommend the hospital for day case surgery varied between 94% and 97%.

Patients told us of their very positive experience in the hospital in respect of the quality of the care and treatment they were receiving. All members of staff treated patients with exceptional kindness, dignity and respect. Staff were very proud of the care they delivered and spoke about patients with utmost respect. We saw the care delivered was very responsive to patient's needs.

Access to care and treatment was monitored and exceeded the national average. Staff acknowledged patient's individual needs and responded to them in an appropriate way. Staff had a good understanding of the complaints process and the hospital learned from complaints, improving services where it was appropriate.

The hospital had a robust governance system in place which included a comprehensive audit system. The staff we spoke with mentioned the provider's values in the form of 'The Ramsay Way' and how they could demonstrate it in their everyday work.

Morale was good with staff talking positively about the organisation and their local management team. Engagement at all levels was good with staff feeling listened to and supported.

Are surgery services safe?

Good

The hospital had systems in place to keep patients safe. Processes were in place to report any incidents. Investigations were robust and staff learned from actions taken as a result. Staff demonstrated a good awareness of the process for identifying and recording any safety incidents.

Arrangements were in place to minimise risks to patients before and after their procedure. Staffing was managed effectively to ensure patients received safe care with access to consultants obtained in a timely manner. All clinical areas were clean and best practice infection prevention and control practices were being followed. Equipment was checked regularly and medicines were stored and administered safely.

Staff had undertaken all mandatory training and were aware of the actions to take in order to safeguard patients. Records were kept securely and we saw they were accurate, up to date and legible.

Incidents

- The organisation had a clear incident reporting policy in place which identified staff responsibilities.
- Staff we spoke with were aware of and had access to the hospital's electronic incident reporting system; all staff knew how to use the system. This allowed staff to report all actual incidents and those where patient safety may have been compromised. Staff gave examples of reportable incidents.
- Staff were aware of incidents where a lesson had been learnt and practices changed as a result. We found investigations into incidents were completed robustly and actions taken as a result of investigations were shared with staff.
- There had been no 'Never' events during the same period. (Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.)

Surgery

- There had been no serious incidents reported between January 2014 and December 2014. During the same time period there had been no deaths or unexpected deaths in the service.
- There had been no transfer of care to a nearby trust for patients between January 2014 and December 2014.
- Staff we spoke with felt confident about raising patient safety issues and reporting them.
- The hospital's matron was aware of the new regulation relating to Duty of Candour. They were aware of their responsibilities in terms of offering an apology to patients, writing to and meeting with patients if harm had been caused.

Safety thermometer

- The hospital monitored patient safety by undertaking a series of assessments to mitigate risks to patients. These included falls, pressure ulcers (damage to the skin caused by a patient being in the same position for too long) and venous thromboembolism (VTE). VTEs or blood clots can form in a vein of a patient and have the potential to cause severe harm.
- The VTE screening for all patients was consistently high in the reporting period between January and December 2014. Screening rates were between 98% and 100%. There had been three cases of hospital acquired VTE in the same period. CQC had assessed the proportion of NHS funded patients risk assessed for VTE to be tending towards better than expected when compared to other independent hospitals.
- A nutritional assessment was undertaken if a patient was deemed to be at risk, for example if they had a body mass index (BMI) of lower than 20 or had experienced unintentional weight loss over the previous six months.
- No pressure ulcers had been reported in the year January to December 2014.

Cleanliness, infection control and hygiene

- Information the provider sent us showed their infection control audits between July 2014 and March 2015 ranged from 85% to 94% compliance.
- As part of the pre-operative process for patients admitted for procedures, high risk patients were screened for methicillin-resistant staphylococcus aureus (MRSA). This was in line with MRSA screening procedures in the local NHS provider. Staff screened patients scheduled for orthopaedic procedures, those who had been in hospital within the previous six months and patients who had previously tested positive for the bacteria. Those patients were screened for MRSA no later than two weeks prior to their operation.
- The hospital had reported no incidence of MRSA, clostridium difficile (C.diff.) or methicillin-sensitive staphylococcus aureus (MSSA) in the reporting period between January to December 2014. MRSA, MSSA and C.diff are all infections that have the capability of causing harm to patients.
- All of the areas in which patients were seen and treated were clean and well maintained. The large sink used by staff for scrubbing their hands prior to undertaking surgical procedures was seen to have a brown stain on the sealant at the back of it. A member of staff informed us it was due to the colour of the antibacterial hand wash used.
- The hospital used a sticker system for ensuring equipment was identified as having been cleaned. The stickers stated 'I am clean' and were placed on equipment which had been cleaned. These were dated and signed appropriately during our announced and unannounced inspections.
- A local policy/procedure was in place for the scrubbing, gowning and gloving of staff prior to surgical interventions. We observed staff following the procedure to ensure infection risk was minimised.
- There were processes and procedures in place for the management, storage and disposal of general and clinical waste, disposal of sharps, environmental cleanliness and the prevention of healthcare acquired infection guidance. We saw clinical waste bags and sharp bins closed effectively and identified with a unique number. There was also a system in place for any sharps bins given to patients on discharge, for example for the administration of certain medicines. This enabled staff to know when they were distributed and returned.
- Staff were seen to wash or apply alcohol gel to their hands between patients. Alcohol gel was available at the entrances to each area and we saw patients encouraged to use it. There was access to hand washing facilities and supplies of personal protective equipment, for example gloves and aprons.
- All staff were observed complying with the bare below the elbows policy.

- Endoscopes were cleaned in a designated sink and decontaminated on site; the cleaning of endoscopes met national decontamination standards.
- Although endoscopies were not being undertaken during our visit, staff informed us the process worked well.
- We found the operating theatre's humidifier had been decommissioned although this had not been removed.
- We were informed there was no stale water in the system and Legionella testing was undertaken every six months. We saw regular testing for Legionella had been completed.
- Microbiological tests had been undertaken on the air system in the theatre when the service had started in 2005. Further microbiological tests had not been completed since then. An insect screen was seen to be in place to prevent small insects from entering the operating theatre's air system.

Environment and equipment

- Storage facilities within the hospital were limited, with the anaesthetic room being used for storing additional equipment. This did not affect patient care as patients walked into theatre prior to their procedure being undertaken. Storage issues had been acknowledged by the provider and plans were being discussed to resolve the situation by the end of 2016.
- Resuscitation equipment was available outside the operating theatre. Single-use items were sealed and in date and we saw evidence the equipment had been checked on a daily basis; this included expiry dates. This meant the equipment was ready for use in an emergency.
- The service also had equipment for dealing with patients who may present with uncommon situations during the course of their operation, for example malignant hyperthermia. Malignant hyperthermia is very rare and causes a fast rise in body temperature and muscle rigidity when the affected person undergoes general anaesthesia.
- We saw all equipment used for patient care was clean and ready for use. Equipment had been routinely checked for safety with portable appliance testing labels stating when the next service was due.
- Anaesthetic equipment was checked by an operating department practitioner (ODP) at the start of each day. We observed records of annual service checks were also in place.
- A system was in place for the request to repair equipment using a pro-forma. We found this was not used as a matter of course. Instead staff members sent emails to the person responsible for maintenance. Of the nine requests we saw, only two had been signed off as complete although we saw the issues had been resolved. This meant assurance could not be gained that issues had been resolved in a timely manner. We spoke with a senior member of the team who informed us this would be taken forward within the hospital with probable changes to the system.

Medicines

- Appropriate arrangements were in place for the ordering and administration of medicines.
- A pharmacy technician visited the hospital twice a week to check all stocks of medicines for expiry dates. A pharmacist visited once a month and undertook controlled drug audits; they also checked the resuscitation trolley medicines. We saw completed audits which showed staff followed the hospital's controlled drugs procedures.
- The medicine cupboard was in a locked room which also contained intravenous solutions. We undertook a random check of five drugs; this showed all drugs were within their expiry date.
- We saw the controlled drugs cupboard which was alarmed; the drugs were stored appropriately. We checked the amounts of two controlled drugs which correlated with the controlled drug record. The records were legible and completed accurately.
- Patients were responsible for completing their own medication questionnaire prior to their procedure being undertaken. Additional information for the patient was sent from the referring GP.
- Medicine charts were in place for patients to ensure the safe administration of medicines.
- We looked at the medicine administration records for six patients across three clinical areas. The records were clear and complete. If people were allergic to any medicines this was recorded.
- All medicines, including those requiring cool storage, were stored appropriately. Records showed that fridge temperatures were recorded on a daily basis, except on a Sunday or Bank Holiday when the hospital was closed. We looked at the temperatures for April 2015. These identified the temperatures were within the acceptable range of two and eight degrees centigrade. The records

also indicated the minimum and maximum temperature of the fridge. We saw the maximum temperature was sometimes outside the acceptable range of two and eight degrees centigrade, for example 12 degrees centigrade. We brought this to the attention of a senior member of staff who told us the issue would be dealt with. On our unannounced inspection on 14 May 2015 we were informed the thermometer had been changed and we saw the maximum and minimum temperatures for the previous week had been in the acceptable range.

- The drug fridge was not secure on the first day of our announced visit. We brought this to the attention of a senior member of staff who locked the fridge. During the second day of our visit and on the unannounced visit the fridge was locked.
- The hospital used a limited number of medicines for relieving pain post-operatively and for patients to take home with them following surgery. Eye drops were also used for patients following ophthalmic surgery. All patients were given information about the medicine they had been prescribed, how to use it and any side effects they may experience.

Records

- The provider had a comprehensive policy in place to ensure records were stored and used appropriately. It had been reviewed and updated in January 2015.
- Records throughout the hospital were stored securely and were readily available. Staff, including reception staff, were aware of their responsibilities with regard to the safe keeping of records and patient confidentiality.
- We looked at three patient records from patients who had undergone three different types of procedures: endoscopy, orthopaedics and ophthalmology.
- We observed records were filed in a specific order. This meant they were easy for staff to locate and use.
- Records were complete and up to date. Each patient had the appropriate care pathway in place, dependent upon the procedure they had undergone and whether it was a local or general anaesthetic.
- Care pathways were comprehensive in content and included pre-operative assessments, anaesthetic, recovery, discharge checklist and outpatient follow up records.
- Records showed where staff had completed patient risk assessments. These included risk assessments for pressure ulcers, falls, and malnutrition. All the risk assessments completed followed national guidance, for example a score for prevention of pressure ulcers.
- Additional information relating to patient's individual care was documented in a communication page.

Safeguarding

- The provider had a policy in place for safeguarding adults which was reviewed in November 2014. It clearly outlined staff's responsibilities in relation to safeguarding adults.
- The hospital had a senior named nurse lead for safeguarding trained to level 3.
- There had been no safeguarding concerns or alerts made for the hospital in the previous 12 months, although a staff member spoke of an issue that had been raised by someone outside the hospital and staff had acted appropriately to protect them.
- Staff we spoke with had an understanding of how to protect patients from abuse. They understood the process and who to refer any concerns to. We saw the process detailing the actions staff needed to take on a noticeboard in the hospital; this meant it was always available to staff.
- Safeguarding adults training was included in the mandatory training for all staff. We were shown evidence that compliance rates were 100% for the current year.

Mandatory training

- We spoke with the training co-ordinator for the hospital. They informed us the hospital closed one day each year to ensure all staff received and completed the face to face mandatory training sessions. Staff we spoke with confirmed this.
- Sessions included customer care, moving and handling, fire, health and safety, basic life support and infection control.
- Other elements of mandatory training were completed using an on-line learning system.
- There was an expectation that all staff completed mandatory training on an annual basis. We were informed staff had to explain if and why they could not attend the annual mandatory training day and were then given an alternative date to attend one of the

provider's other hospitals to receive it. We were informed of one member of staff who had gone through the process of attending mandatory training at another hospital.
- 100% of staff had completed their mandatory training for the year 2014/2015.

Assessing and responding to patient risk

- All patients attending the hospital saw a consultant at each stage of their patient journey. Nursing and medical staff completed pre-operative assessments for patients undergoing surgery. This was completed during a pre-operative assessment appointment or before scheduled appointments for surgery, dependent on the type of surgery due to be performed. Ophthalmic patients requiring surgical procedures could see one of a number of consultants depending on which one was undertaking appointments on the day of the visit; this included surgical procedures.
- Anaesthetists calculated the patient's American Society of Anesthesiologists (ASA) grade as part of their assessment of a patient to undergo a general anaesthetic. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels. The hospital only undertook procedures for patients graded as levels one to three; this was clearly explained in the acceptance criteria for patients being treated in the hospital. Commissioners of the service did not contract for services to be undertaken on patients with an ASA grade of between four and six.
- We found the anaesthetic records we reviewed showed the ASA grade had been used and in practice only patients with an ASA grade of one or two had undergone procedures under a general anaesthetic.
- Staff in the hospital used a system to record routine physiological observations such as blood pressure, temperature and heart rate in order to monitor a patient's clinical condition. This was used as part of an early warning score (EWS). Staff reviewed patients' EWS. If a patient's score increased, staff were alerted to the fact and a response was instigated. The response varied from increasing the frequency of the patient's observations up to urgent review by the consultant surgeon and/or consultant anaesthetist. We observed records which showed staff completed EWS reviews.
- The hospital had a service level agreement with the local NHS acute trust. This stated patients could be transferred to their care if they deteriorated. An emergency call to the ambulance service would be made to transport a patient if a transfer was required.
- At least one staff member who had undertaken training in advanced life support (ALS) was available for each operating session during the week.
- Staff we spoke with felt confident about contacting the patient's consultant by telephone and told us the consultant would attend the patient in a short period of time.
- The hospital followed the five steps to safer surgery in the operating theatre. Staff used a document based on the World Health Organisation (WHO) safety procedures for use in an operating theatre to ensure any risk to patients was mitigated. However, this had been adapted for certain procedures such as cataract surgery (performed under local anaesthetic), and endoscopy. This meant the WHO checklists were surgery specific. Medical records we reviewed showed the WHO checklist had been completed in all cases.
- During our observation in theatre we observed staff adhering to the checklists and signing them off.
- The provider had a wound care management policy/ procedure in place which was in use in the hospital. Staff were aware of this.
- Patients were given wound management advice from their nurse before discharge which was supported by written information they could take away. The information included what the patient should do if they were concerned.
- Information received from the provider showed that six incidents of wound infection had occurred between May 2014 and April 2015. All of the incidents had been logged on the hospital's on-line incident reporting system and all patients had been treated appropriately.
- Hospital staff telephoned each patient 24 hours after their procedure. Any concerns about their wound could be raised at that time and staff gave appropriate advice including revisiting the hospital.

Nursing staffing

- None of the patients receiving care and treatment stayed overnight in the hospital; all were day case patients, the hospital was open typically from 7.30am until 8pm.

Surgery

- Staff were present in the hospital until the last patient was fit to be discharged home.
- During our inspection all the staff we spoke with told us they had enough staff on duty to deliver good quality care even though they were sometimes very busy.
- The provider informed us prior to the inspection that a new rostering management system had been introduced in March 2015. Prior to the new system being introduced the hospital used a staff rota system to track and monitor the hours staff worked.
- The new rostering system allowed heads of department to manage rotas, skill mix and staff requirements including senior cover. It also meant heads of department could manage sickness and annual leave absences.
- Staffing levels were reviewed daily to enable team leaders in the clinical areas to flex their staffing, according to patient requirements.
- Patients told us there were sufficient staff to meet their needs during their visit to the hospital.
- The expected numbers for nurse staffing across all departments at the hospital, which included outpatients, theatre and recovery was nine whole time equivalent (WTE) staff. This included a nurse manager, two team leaders, registered nurses and care assistants.
- A further 2.8 WTE operating department practitioners (ODP) were also employed. One of the ODPs acted as a team leader for theatre staff.
- The hospital had not used any agency staff for the twelve months prior to our visit.
- The hospital used their own dedicated bank staff on a regular or occasional basis dependent upon need, for example to cover sickness or annual leave. In addition, regular staff had the opportunity to work additional hours if they wished to. This meant only staff that knew the hospital and had undertaken an appropriate induction and competency based framework worked in the hospital. The provider was actively discussing employment of more staff to reduce the dependency on overtime.
- Nursing staff rotated between outpatients and the recovery area to ensure their continued competency in each area. Daily staffing levels in the recovery area was flexed dependent upon the type of surgical procedures being undertaken. For example procedures performed using general anaesthetic required a higher nurse to patient ratio than local anaesthetics.

Surgical staffing

- The provider employed 1.6 whole time equivalent (WTE) consultants in the hospital; the consultants were an anaesthetist and a surgeon. The remaining 34 consultants worked under practising privileges from the local NHS trust on a rotational basis. They included consultants with specialties such as ophthalmology, urology and orthopaedics. The term "practising privileges" refers to medical practitioners being granted the right to practise in a hospital. The hospital only provided day care and therefore did not provide a resident medical officer.
- At least one consultant was present throughout the hospital's operating hours.
- Staff informed us they had no concerns about obtaining medical help quickly if it was needed to review a patient's care.
- A consultant anaesthetist was present in the hospital for both operating lists each day. This meant they could respond quickly in an emergency and reduce any risk to patients.

Major incident awareness and training

- The hospital had business continuity plans in place in case of potential emergencies. This included fire, floods and problems with the building as well as medical emergencies. Staff were aware of the plans in place.
- Two different scenarios were given to the hospital every six months by the provider as a desktop exercise, for example a flood and a suspicious package. These had been dealt with appropriately.
- The hospital did not have designated roles and responsibilities in the nearby trust's major incident policy. However, a senior member of the hospital team informed us they would always support the trust if it was necessary.

Are surgery services effective?

Good

Evidence based assessment, care and treatment was delivered to patients following national guidance by appropriately qualified and competent staff. Patients

received pain relief appropriate to their needs in a timely manner. Outcomes for patients were monitored on an on-going basis and either met or exceeded the provider's expected targets.

A multi-disciplinary team approach was in evidence and we observed this throughout our inspection. The hospital provided a six day per week service with senior nursing staff providing a 24 hour telephone service to discharged patients in case of concerns. Patients had good access to information.

Evidence-based care and treatment

- The hospital had been awarded accreditation by the Joint Advisory Group (JAG) on gastrointestinal endoscopy and was the first independent hospital to achieve this. JAG accreditation is a national award given to facilities that reach a gold standard in various aspects of their endoscopy service, including patient experience, clinical quality and decontamination of equipment.
- The hospital had been reassessed in October 2014. The report highlighted some areas of excellence, including advising patients post procedure and the communication between staff members of the team.
- Recommendations in the report included using more up to date endoscopes to provide better imaging (pictures) and flexibility. During our inspection we saw evidence that as a result of the report the provider had ordered three standard adult colonoscopes for viewing the bowel and three adult gastroscopes for viewing the oesophagus or food pipe and the stomach.
- JAG visits to hospitals or units undertaking scoping are held every five years, but accreditation is issued annually following successful completion of an annual report card.
- The delivery of surgical care was consistent with the British Association of Day Surgery (BADS). BADS promotes excellence in day surgery and provides information to patients, relatives, carers, healthcare professionals and members of the association.
- Patient needs were assessed throughout their care pathway. Care and treatment was delivered in line with the provider's policies and guidelines and with National Institute of Health and Care Excellence (NICE) quality standards. For example, staff followed guidance in regards to venous thromboembolism (VTE) and falls assessment and prevention.
- The hospital had met all 2014/15 commissioning for quality and innovation (CQUIN) requirements from the clinical commissioning group (CCG). These had included falls assessments and dementia screening.
- CQUINS had been agreed with commissioners for 2015/16 and included five steps to safer surgery and minimising patient harm in surgery.
- Staff completed theatre audits following a planned audit programme for 2014/15. In February 2015 staff completed a surgical safety audit, which showed 100% compliance. Staff had completed surgical site infection audits in November 2014 and February 2015. Compliance in November 2014 had been 89%, which had risen to 91% in February 2015.

Pain relief

- Prior to surgery, patients were informed about the pain assessment score the hospital used for identifying the level of pain they may experience. This enabled the patient to communicate effectively with staff and obtain the correct pain relieving medication following their surgery.
- A patient information leaflet "Managing your pain after your operation," was handed to patients prior to their surgery. It explained the pain assessment score and gave information about eight different medicines that may be used to control their pain.
- We were informed pain relief was given as routine on discharge unless patients were on stronger pain relieving medicines on a regular basis prior to surgery.
- We looked at six patient records, these demonstrated staff were identifying levels of pain and ensuring pain relief was given in a timely manner. The hospital's patient questionnaire responses for Quarter 3 (October to December) 2014 indicated that 100% of patients thought staff did everything they could to control their pain.

Nutrition and hydration

- Patients were screened for malnutrition and the risk of malnutrition when they were identified as being at risk, for example if they had unexplained weight loss over the previous three months. The tool used was the Malnutrition Universal Screening Tool (MUST).

- Staff followed guidance on fasting prior to surgery which was based on best practice. For healthy patients requiring a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- The hospital provided only day surgery, therefore meals were not provided. A selection of hot drinks and biscuits were available to patients once they had recovered from their procedure and prior to discharge.

Patient outcomes

- Of the 3,298 patients receiving treatment at the hospital, three had been required to return to theatre between January and December 2014. We have assessed this as 'tending towards better than expected' compared to other independent hospitals.
- Patient reported outcome measures (PROMS) for the period April 2013 to March 2014 assessed patient outcomes for the repair of groin hernias. These were significantly better compared to the England average.
- Data we received during our visit showed that following nationally audited procedures for groin hernias, one of the consultants working in the hospital had been placed in the top quartile for the country for quality outcomes for their patients.
- The British Society of Gastroenterologists (BSG) set a standard of 90% for successful caecal intubation during colonoscopy procedures. Caecal intubation is a marker of full colonoscopy and enables the operator to see the entire colon. When supported by other performance measures it contributes to a high quality patient-centred outcome.
- Five clinicians undertook colonoscopy procedures at the hospital. Colonoscopy performance data for the reporting period January 2015 to March 2015 showed two endoscopists had achieved 100% of the standard. A further two of the five endoscopists had not achieved the standard, although the number of procedures they had undertaken had been low and the performance of these endoscopists had been monitored.
- Clinical outcomes were reviewed against joint advisory group (JAG) standards and any variation would be discussed with the individual clinician with appropriate action taken when necessary including further training.
- Fifty eight different surgical procedures had been chosen to be undertaken at the hospital after a multidisciplinary meeting in 2011. All of the procedures followed National Institute for Health and Care Excellence (NICE) best practice guidance. Any additional procedures needed at the hospital were required to go through the Medical Advisory Committee for acceptance before being added onto the hospital's procedure list.
- An incident raised the weekend before our visit highlighted a procedure that had been ineffective because of inappropriate equipment being used for the patient. This was placed on the hospital's electronic incident recording system. We discussed this with senior managers and were assured the issue was being dealt with through the purchasing of new equipment that would be delivered as soon as possible. On our unannounced inspection, we checked if the equipment had been delivered but it had not due to a backlog of orders at the manufacturer.
- Patients did not leave the hospital after their procedure until they had received their own copy of the discharge summary letter. GPs of discharged patients were faxed a copy of the letter on the day of discharge. This ensured GPs knew as soon as possible of the procedure and any further treatment required.

Competent staff

- The percentage of staff who had completed appraisals in 2014 was 100%.
- For consultants with practising privileges, the hospital kept a record of their employing NHS trust together with the responsible officer's (RO) name. The term "practising privileges" refers to medical practitioners being granted the right to practise in a hospital.
- Applications for practising privileges from consultants were granted or rejected by the Medical Advisory Committee (MAC) of the provider. This involved checking their suitability to work at the hospital, checks on their qualifications as well as references and disclosure and barring checking with the Disclosure and Barring Service (DBS). There was a system in place to ensure doctors had undergone revalidation.
- We reviewed data for the appraisal rates for medical staff. This showed that all consultants had received an appraisal in the previous year.
- The hospital manager informed us there had been no competency issues with regard to any of the consultants working in the hospital. However, there were robust processes in place for both provider employed consultants and those with practicing privileges to

ensure issues were dealt with appropriately. The responsible person at the employing NHS trust for medical staff working with practising privileges at the hospital would also be contacted.

- The provider had systems in place to ensure qualified doctors' and nurses' registration status had been renewed as required. For example the rostering system for nurses alerted the team leaders and manager when re-registration was due. The system would not permit nurses to be rostered for duty until re-registration had been completed.
- All staff received a supernumerary induction lasting for two weeks when they commenced employment at the hospital.
- Following on from this, they remained supernumerary (additional to the rostered staff) until their competencies had been achieved and signed off by a senior member of staff; the time for completion varied for individuals and included items such as critical care and phlebotomy (taking blood). We saw an induction book for one recently appointed member of staff. The last entry was dated 10 April 2015 and had been signed off.
- Staff informed us induction and competency processes had been comprehensive and they had felt competent to undertake their role on completion. For example, only qualified nursing staff who had been trained or were competent in the process undertook pre-operative assessments of patients.
- The provider had a robust system in place to ensure qualified nurses continued to maintain their registration in order to practice as nurses.
- Senior members of nursing staff were aware of the new revalidation process for registered nurses, which was out to consultation at the time of our inspection. Revalidation promotes good practice across the whole population of nurses and midwives. The process includes continuing professional development and receiving feedback on clinical practice. This will occur every three years. The provider was looking at revalidation and putting a system in place to support nurses; it had not yet been finalised.
- Each consultant undertaking endoscopy processes accessed the joint advisory group (JAG) endoscopy training system to ensure they completed endoscopic training courses appropriate to their needs. Their performance was monitored by the manager to record progress and competencies for submission to the JAG for accreditation.
- The hospital was offering an apprenticeship to a healthcare assistant who was supported by a training college.

Multidisciplinary working

- We found a multi-disciplinary team (MDT) approach was evident across all of the hospital areas we visited and included staff at every level.
- Systems were in place to expand the MDT process if a patient required it, for example referral to an acute trust for urgent action after results of histology (tests on tissue samples taken) were known.
- Staff in the theatre held a 'safety huddle' prior to each list commencing. These were brief face-to-face meetings with staff involved in the operating list. Any concerns about safety and the forthcoming operating list were discussed. Staff we spoke with felt empowered to raise any concerns they may have at any time. These meetings were documented.
- Physiotherapy services were available. These were provided by a professional from another hospital owned by the provider who attended the hospital once a week to treat patients, when it was necessary.

Seven-day services

- The hospital had one operating theatre which was used six days a week. All surgical procedures took place in the theatre including endoscopies.
- Consultants were responsible for the care of their patients from pre-admission consultation until the conclusion of their episode of care.
- A limited amount of post-operative medication could be prescribed and dispensed to patients prior to their discharge. This was available at all times the hospital was open.
- Patients had access to an on-call senior nurse 24 hours a day. The system worked on a rotational basis.
- Other services, for example equipment engineers were called for when it was necessary.

Access to information

- Staff used a comprehensive standard operating procedure for patients undergoing any form of local or general anaesthesia for day case surgery. This included

main quality indicators of anaesthesia, management of pain and recommendations for the management of post discharge complications. Therefore staff had access to and used a standard system which provided information for each patient admitted.
- Patient's NHS notes from the acute trust were not available at the hospital although GPs provided comprehensive information about patients prior to their initial consultation. This ensured the hospital had the information required to make informed judgements about patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a comprehensive policy on obtaining consent and staff we spoke with were aware of it. Within the policy was a section on ensuring the patient could make informed consent to treatment and what to do if they were unable to do so.
- The hospital used a two part consent form. The first included a statement and signature by the health professional about the procedure and any identified risks. It also included a statement by the patient regarding their understanding of the procedure with their signature to consent to the procedure. Completion of this was undertaken at their initial consultation. The second part of the consent form related to the confirmation of consent; this was undertaken immediately prior to the procedure being undertaken. At that point patients could refuse to give their consent and this was clearly identified.
- We reviewed six records which showed the consent forms had been clearly completed, dated and signed appropriately.
- Patients we spoke with informed us they were given as much information as they required from their consultant prior to their operation to give informed consent and any risks had been explained to them.
- The provider had a policy, reviewed in April 2015, in place relating to mental capacity. It referred to the Mental Capacity Act 2005 and the related code of practice.
- A senior member of staff informed us the hospital occasionally treated patients who they were concerned lacked the capacity to make informed choices or give consent. In those instances, staff alerted the consultant and a mental capacity assessment was undertaken to determine whether a patient was able to make informed consent decisions; these were documented. Any 'best interest' decisions taken as a result of capacity assessments were also documented.

Are surgery services caring?

Good

The care we observed in the hospital was very good. Patients were not rushed and were treated as individuals. Staff were very attentive and compassionate, with patients being involved at every stage of their treatment.

Patients told us of their very positive experience in the hospital in respect of the quality of the care and treatment they were receiving. All members of staff treated patients with exceptional kindness, dignity and respect. Staff were very proud of the care they delivered and spoke about patients with utmost respect. We saw the care delivered was very responsive to patient's needs.

The hospital did not use the NHS Friends and Family Test and instead gathered its own patient feedback. Between January 2015 and March 2015 the percentage of patients who were extremely likely to recommend the hospital for day case surgery varied between 94% and 97%.

Compassionate care

- The patients we spoke with were very positive about their experience of treatment at the hospital. They told us they were treated with dignity and respect and staff were caring towards them.
- Staff took time to ensure patients were provided with shorts, which were specifically designed for colonoscopy procedures, in order to protect their dignity.
- Two of the patients compared their experience of the hospital with that of care in other settings. They told us they were much more satisfied with the hospital because of the individual attention they received from medical and nursing staff and the respect they were given.
- We observed staff approaching patients in a respectful way. All staff supported patients in a professional and sensitive manner.
- We observed nursing staff to be exceptionally responsive to patients' needs following their surgery, in

that they were caring and attentive to their patients, especially with regard to pain relief. In the recovery area patients were cared for on a one-to-one nurse-patient ratio when patients were initially recovering from a general anaesthetic.

- The care we observed patients receive was exceptionally responsive to their needs, for example, pre-empting patients' pain and providing them with suitable pain relief to ensure they did not become distressed.
- Staff told us they were proud of the high quality patient care they were able to deliver in the hospital which gave them high levels of job satisfaction.
- The hospital did not use the NHS Friends and Family test. Responses from the hospital's own patient feedback showed consistently high levels of satisfaction with the service provided in the reporting period from July 2014 to December 2014.
- Response rates for the hospital's question to patients as to whether they would recommend the hospital to family and friends had been between 70% and 89% for the time period January 2015 and March 2015. In this time period, the percentage of patients who were extremely likely to recommend the hospital for day case surgery varied between 94% and 97%.

Understanding and involvement of patients and those close to them

- At all times we observed patients were treated on an individual basis and not rushed. This enabled patients to ask questions if they felt it necessary or were concerned about anything.
- During our observations in the hospital we observed good interactions between staff and patients ensuring patients had understood what had been said to them. When necessary and if appropriate either before or following a treatment, staff spoke with people who had come to support a patient. This helped to ensure the person supporting the patient understood any after care that was required.
- On-going engagement with patients was undertaken using the provider's 'We value your opinion' comment cards; approximately 70 compliments about care and treatment were received every month.

Emotional support

- We asked staff about the emotional support available to patients who may have received bad news following a procedure. Although an identified relative's room was not available at the hospital, when necessary, staff used a room away from the reception area in order to give patients and their relatives time to absorb the news and ask any questions they may have.

Are surgery services responsive?

Good

Access to care and treatment was monitored and exceeded the national average. Staff acknowledged patient's individual needs and responded to them in an appropriate way. Patient information leaflets, following national guidance, were available relating to surgical procedures undertaken at the hospital. The national standard for referral to treatment (RTT) time stated that 95% of patients should start consultant led treatment within 18 weeks of referral. Data showed that between October 2014 and February 2015 100% of patients were seen within this 18 week target.

Staff had a good understanding of the complaints process and the hospital learned from complaints, improving service delivery if it was required. We reviewed the complaints process completed by hospital staff. We found staff had followed the provider's complaints procedures.

Service planning and delivery to meet the needs of local people

- The hospital had been established in 2005 as a dedicated purpose built day care centre for a period of five years to deliver day case surgery in the private sector. This had resulted in local people receiving timely interventions for their required procedures.
- In 2010 the hospital had commenced NHS referrals through the 'Choose and Book' system via their GP. In addition they also commenced a service to self-funding patients. Only 93 of the 3,298 patients receiving surgery at the hospital in 2014 had been self-funded.
- Plans were in place to increase the capacity in the hospital by developing the facility which would provide more service availability for local people. We were informed by senior staff this should commence in 2016.

Surgery

- The hospital cared for people of all sexes. Care and treatment pre and post operatively was undertaken in areas where individual patients could be segregated via curtains or doors to provide privacy.

Access and flow

- The national standard for referral to treatment (RTT) time stated that 95% of patients should start consultant led treatment within 18 weeks of referral. Data showed that between October 2014 and February 2015 100% of patients were seen within this 18 week target.
- Patients waiting for an endoscopy were usually seen within two to four weeks of referral.
- Appointments for surgical procedures were routinely made on the same day as the patient saw the consultant at their initial outpatient appointment.
- The hospital reported that long waiting times for patients after arrival for their appointments was not a problem; however the hospital did not have data available. Senior management staff told us this was because lengthy wait times were not an issue.
- We were told by staff on rare occasions if patients' appointments were delayed and they could not wait, the hospital would re-book them as quickly as possible at a time that was convenient to the patient. Updates on waiting times were given to patients verbally by nursing or reception staff if clinics were delayed and an apology offered.
- 'Choose and book' is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. No patients we spoke to reported any problems with the booking of their initial appointment and two indicated they had actively chosen the hospital based upon the positive experiences of friends and family at the hospital.
- Patients were admitted to endoscopy via outpatient clinics or by their GP.

Meeting people's individual needs

- Patient information leaflets, following national guidance, were available relating to surgical procedures undertaken at the hospital.
- Each patient undergoing an endoscopy procedure was asked what type of anaesthetic or sedation they wished to have, for example a throat spray or an injection. Staff explained the process and responded accordingly ensuring it met the patient's needs and wishes.
- 'Post discharge advice' information leaflets were given to patients upon discharge from the hospital. The leaflets included a checklist of questions for patients to ask themselves to test their understanding of the most important aspects of their care before going home. Examples of questions included; was the patient aware of how to use the 24 hour helpline to seek advice, when and how to take medication and when was the patient's next appointment with the doctor.
- The hospital had a telephone service for accessing interpreters if required when patients' first language was not English.
- Interpretation services could be accessed by staff during nurse assessment clinics, and on the day of a patient's surgery. Patients requiring an interpretation service prior to their surgery were listed at the beginning or end of a surgical list to enable the patient's doctor and their anaesthetist to be part of the interpretation telephone call. This meant that any questions from the patient to either the surgeon or anaesthetist could be addressed during the call.
- Any information leaflets given to patients were in English only. Staff told us the majority of patients for whom English was not their first language, had requested English language leaflets.
- When patients attended the hospital who had specific needs for example poor mobility, these were individually assessed and addressed. Patients with learning disabilities or who were living with a dementia were able to have their carer present for most of their treatment.
- Two members of staff had received additional training to meet the needs of people living with dementia; they were called 'dementia champions'. They were responsible for cascading the training they had received to other members of staff. The majority of nursing staff had undertaken an e-learning course on dementia awareness and were aware of how to respond to those patients. Toilets had the appropriate signage in place to alert patients living with dementia.
- We saw signs displayed in public and treatment areas explaining the hospital's chaperone policy. The policy stated a chaperone would be provided by the hospital during all hospital consultations if the patient did not bring a suitable person with them.

Surgery

Learning from complaints and concerns

- Policies and procedures were in place relating to complaint handling. This included ensuring all complaints were logged onto the hospital's incident reporting system and reported to the manager.
- Complaints leaflets were available in the waiting area for patients to use when required.
- Staff informed us they would speak to anyone raising a complaint at the time they raised it. The aim was to try and resolve the issue at the earliest opportunity.
- The registered manager or matron of the hospital spoke with all complainants, reviewed the complaint and sent a written response after an investigation had been completed.
- The Clinical Governance Committee reviewed all complaints and discussed possible trends. If the complaint involved a consultant this was raised with the chair of the Medical Advisory Committee to take forward.
- Complaints were also discussed with all members of staff, with any learning points identified and addressed. That meant the hospital learned from complaints and improved services where appropriate.
- We reviewed the complaints process completed by hospital staff. We found staff had followed the provider's complaints procedures.

Are surgery services well-led?

Good

The hospital had a robust governance system in place. This incorporated a series of ten different staff and patient groups who held regular meetings. Outcomes of all meetings fed into regional and corporate information including the financial position of the hospital.

The hospital had a manager, matron and medical director who provided professional leadership for all clinical staff. Senior management staff were visible and staff informed us of their ability to approach them without question for guidance and support when necessary.

The staff we spoke with mentioned the provider's values in the form of 'The Ramsay Way' and how they could demonstrate it in their every day work.

Morale was good with most staff talking positively about the organisation and their local management team. Engagement at all levels was good with staff feeling listened to and supported.

Vision and strategy for this service

- As part of a large provider organisation, the hospital had copies of 'The Ramsay Way' in public areas and on noticeboards. This described the provider's purpose and values for health care provision which was replicated in all of the provider's health care facilities.
- The staff we spoke with were able to refer to the elements of 'The Ramsay Way', for example caring and teamwork and explain how their role fitted in with it. They told us it was something which was mentioned on a very regular basis during meetings.
- Staff were aware of the plans to enlarge the hospital in the near future.

Governance, risk management and quality measurement

- A rolling programme of audits was undertaken each month, for example documentation, WHO (World Health Organisation) surgical checklists and infection control issues. The results showed fairly consistent high levels of completion with only a few occasional gaps.
- A report of all the audit activity was collated each month. This included details of any actions to be taken and timescales for completion.
- The hospital had a robust governance process in place. This incorporated a series of ten different staff and patient groups meeting to discuss issues related to incidents, risk and patient experience. Examples of the groups included a three monthly patient participation group, health and safety, infection prevention and control and the medical advisory committee. Staff forums were held on a monthly and three monthly basis. We reviewed minutes from those meetings and saw a number of standing agenda items, for example complaints and incidents, including trends, and risk register updates.
- Outcomes of all meetings fed into regional and corporate information including the financial position of the hospital.
- We saw the hospital had a risk register in place, which showed current risks. It documented a named

individual responsible for the actions taken to reduce the risk, with a review date. The risk register was monitored through the clinical governance committee meeting.
- The clinical governance meeting also discussed morbidity and mortality data when necessary.
- There was a positive working relationship with the commissioners of the service, a local clinical commissioning group. The commissioners reviewed the hospital's performance on a regular basis via their results of specific measured outcomes for quality and innovation (CQUIN). Senior staff from the hospital met with the commissioners of their services on a regular basis to ensure quality outcomes were being met. For example falls assessments and dementia screening. In 2014/15 the hospital had undertaken dementia screening on all people over the age of 75 years using their service. If a screening result which indicated a risk of possible dementia was noted, the patient was referred back to their GP for more comprehensive assessment.

Leadership of service

- Team leaders were available in all areas of the hospital and were visible to staff. Staff knew who to approach if they had any concerns.
- The hospital had a registered manager, matron and medical director who provided professional leadership for all clinical staff. Senior management staff were visible and staff informed us of their ability to approach them without question for guidance and support when necessary.
- The matron undertook shifts in clinical areas ensuring their practice was up to date and they had knowledge of issues concerning other staff members.
- The medical director undertook surgical procedures in the hospital on a regular basis. The chair of the hospital's local Medical Advisory Committee (MAC) was a member of the provider's regional MAC.
- All the staff we spoke with described the local senior team as having adopted an 'open door' policy.

Culture within the service

- Staff we spoke with told us of their commitment to providing safe, compassionate and caring services to their patients. They spoke positively about the morale in the hospital and the care they delivered: we saw this when undertaking observations
- Staff told us they felt they had the time to care for their patients on an individual basis; this created a calm atmosphere in the hospital which benefited both patients and staff. Staff told us they felt valued and involved in any operational changes. Staff told us they were proud to work at the hospital.
- There was an open culture in the hospital with non-medical staff feeling equal members of the team to medical staff.
- Following the staff survey in 2014, staff in the hospital had developed a staff charter. We saw this was displayed, but only in the rear of the hospital. The charter included 11 items, for example respecting other colleagues, recognising each other's contribution and offering support for each other. Staff were aware of the charter and could quote items from it when we asked.

Public and staff engagement

- Patient partnership groups were set up two years ago to help resolve any concerns raised by patients. As well as meeting on a quarterly basis, 'virtual' groups had been developed with patients corresponding via email. This had proved successful.
- A senior member of staff informed us the relationship between the local Healthwatch group and the hospital was very good. Any complaints received by Healthwatch were passed onto the hospital to investigate. Feedback was always given to Healthwatch after investigation.
- A staff survey was conducted on an annual basis. We saw the results of the 2014 staff survey and how actions had been taken to respond to issues raised. We saw staff had been encouraged to feedback openly in their staff survey responses. All staff had attended the action plan meeting which followed the completion of the staff survey.

Innovation, improvement and sustainability

- Plans were being put into place to increase the number of patients treated at the hospital by adding an additional theatre and redesigning the current space. This was expected to be concluded in 2016 and will result in more local people having access to the hospital's services.

Outpatients and diagnostic imaging

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

Information about the service

Boston West Hospital provided outpatient and diagnostic imaging services to adult patients for a number of specialties including orthopaedic surgery; urology; ophthalmology; endoscopy; general surgery; gynaecology and pain management surgical procedures.

The hospital's outpatient facilities consisted of three consulting/examination rooms, one consulting room and one examination/treatment room. Between January and December 2014, 3,493 outpatients were seen for a first visit and 6,735 outpatients were seen for follow up visits at the hospital. These were all NHS patients. In the same time period, 89 private patients were seen for a first visit and 121 private patients were seen for a follow-up visit.

Diagnostic imaging was available at the hospital using a portable c-arm x-ray machine. Other diagnostic images, for example x-rays which could not be taken using the hospital's c-arm x-ray machine, magnetic resonance imaging (MRI) or computerised tomography (CT) scanning were available however these imaging services were outsourced and took place at another of the provider's hospitals or a nearby NHS trust hospital. Other outsourced services included pathology and pharmacy services.

We visited all areas of the hospital during the inspection.

Summary of findings

Overall the outpatients and diagnostic imaging service at the hospital was rated as good. We found that appropriate systems to respond to and learn from incidents were in place, as were systems to help protect people from harm or abuse. Patient areas were clean and tidy and infection prevention and control practices were followed. Systems were in place to ensure equipment was well maintained and medicines were well managed. The hospital had access to a radiation protection supervisor and radiation protection adviser in accordance with the ionising radiation (medical exposure) regulations and had practices and systems in place in accordance with the legislation.

Patients spoke highly of the care they received and felt involved in and understood their care and treatment. The environment of the hospital was comfortable for patients with sufficient seating in waiting areas, drinks were available and sufficient on site car parking. Support was given to patients; both in the out-patient department and via a 24 hour telephone helpline run by hospital staff which was available to patients when not attending the hospital. Patient satisfaction was high with recent data showing that 90% of outpatients would recommend the hospital to their family and friends as a place to receive treatment and care.

Systems were in place to ensure staff were appropriately qualified to deliver care and treatment. Staff reported that management was supportive and they had access to a wide range of training opportunities to help develop

their skills further. The hospital management encouraged feedback from both patients and staff and reviewed this during governance meetings to help inform changes to improve the service. Complaints were taken seriously with processes in place to learn from them and share this learning with staff through the hospital's governance meetings.

Are outpatient and diagnostic imaging services safe?

Good

Staff were aware of how to report incidents and processes were in place to investigate and learn from them. Staff knew of their responsibilities with regards to the safeguarding of adults and had received relevant mandatory training. There were sufficient staff with the appropriate skill mix to meet the needs of the patients.

Systems were in place to ensure medicines were managed safely and stored appropriately. Cleanliness and hygiene standards were of an acceptable standard and audits took place to ensure cleanliness and hygiene levels were maintained. Patient records were stored securely and were up to date.

Incidents

- Data provided by the hospital showed there had been no serious incidents between January and December 2014.
- There had been no radiological imaging related incidents at the hospital.
- Staff were aware of the hospital's incident reporting system. Staff were encouraged to report all incidents using the hospital's electronic system; an investigation was then undertaken. A safety scoring matrix was used to give each incident a severity rating. As part of the investigation, if applicable, patients affected by an incident were contacted for further information and follow up.
- Learning and any trends identified from incidents were shared through internal meetings and at clinical governance meetings. This meant lessons were learned from such incidents and if required processes or clinical practice was changed as a result.
- The hospital's matron was aware of the new regulation relating to Duty of Candour. They were aware of their responsibilities in terms of offering an apology to patients, writing to and meeting with patients if harm had been caused.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- Data provided by the hospital showed that no incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C-Diff) or Methicillin Sensitive Staphylococcus Aureus (MSSA) had occurred during the reporting period from January to December 2014.
- Audits were undertaken at the hospital to monitor the care that was being delivered and identify areas for improvement or procedures that were not being followed as expected. These audits included checks on infection control and hygiene for example, audits of hand hygiene. We saw staff had completed audit checklists on a regular basis.Throughout the inspection, staff were observed washing their hands and/or applying sanitising gel in between caring for patients and when moving between different areas of the hospital. Hand washing facilities were available throughout the treatment areas and personal protective equipment such as gloves and aprons were available to staff.
- All patient areas were clean and tidy. We saw green 'I am clean' stickers placed on equipment and chairs indicating that they had been cleaned. These stickers included the date, time and the initials of the person who had undertaken the cleaning. The housekeeping team cleaned furniture and rooms; nursing staff were responsible for cleaning equipment.
- A new system to record cleaning of out-patient areas had been implemented at the beginning of April 2015. We saw evidence that records were complete.

Environment and equipment

- Resuscitation equipment was available in outpatient areas. Daily checks of the equipment included checks on the defibrillator, oxygen cylinder, oxygen face masks, suction equipment, sharps bin, adult defibrillator pads, disposable gloves, disposable face masks and cleaning of the trolley's surfaces.
- Audits of compliance with the daily and weekly checks of the resuscitation trolley were undertaken. Audit results from March 2015 showed that on five occasions the daily checks had not been completed on days that they should have been. Following the audit, staff responsible for undertaking the checks were reminded of the importance of undertaking the daily checks by the nursing team leaders following a review of the audit results in the resuscitation and critical care meetings. A review of the daily check records for April 2015 showed an improvement in completion of daily checks, with only one day omitted.
- Weekly checks included checks on all drugs and consumables to make sure they were available and in date. Drugs and consumables were stored in the drawers of the resuscitation trolley which were secured by a tamper proof seal after the weekly checks were completed. The unique identification number of the tamper proof seal was recorded and checked as part of the weekly trolley checks to identify if the trolley's drawers had been opened and re-sealed in between checks.
- We were told all nursing staff and healthcare assistants had undertaken intermediate life support (ILS) training last year and all nursing staff were timetabled to undertake the checks of the resuscitation trolley on a daily basis.
- A portable c-arm x-ray machine used for taking radiological images, underwent a check by the operator prior to every period when it was to be used, for example during a series of pain clinics. Radiological equipment was regularly maintained as part of a service contract.
- Radiological imaging equipment was used in the operating theatre area which had restricted access. The hospital had systems in place to notify staff when radiological imaging equipment was in use. Specialist personal protective equipment (PPE), lead aprons, were available for hospital staff when radiological images were being taken. However, we were informed no checks on the PPE were being undertaken.
- Sharps boxes, containers used to collect medical needles and other sharp medical instruments, were available throughout the hospital and were located in treatment, pre-surgery and recovery areas close to the point of use, for example in recovery bays and treatment rooms.
- Sharps boxes were in areas with restricted patient access and were secure. Once opened and when filled and sealed, the sharps boxes were signed and dated in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Other clinical waste was collected in clinical waste bags which again, once full were securely sealed and stored pending collection for off-site disposal.

Outpatients and diagnostic imaging

Medicines

- Information from the hospital showed there had been no medication errors between December 2014 and March 2015.
- Medicines were stored in two areas; a locked medicines fridge and a locked storage cupboard for medicines stored at room temperature. Both of these medicine stores were in the theatre complex which was not accessible to patients unless accompanied by hospital staff. During the inspection it was seen that the medicine fridge's padlock was not secure. This was fed back to the hospital manager who locked the fridge. On a later visit the following day and during our unannounced visit, the fridge was locked.
- Medicines in the cupboard were stored, administered and checked appropriately.
- A random check of five drugs held in the storage cupboard showed all five were within their 'use by' dates.
- The hospital had a locked and alarmed controlled drugs storage cupboard. Checks on the amounts of two controlled drugs were undertaken. The amounts of the drugs available was equal to the amounts expected and documented on the controlled drugs chart.
- The current, minimum and maximum temperatures of both ambient and chilled medicine storage areas were monitored and recorded during days when the hospital was open. There were occasions where the maximum and minimum recorded temperature of the fridge had exceeded the desired 2oC - 8oC range. The temperature monitoring device had been reset but advice had not been sought from a pharmacist with regards to the safety of the drugs in storage. We were told that further advice on temperature monitoring would be sought from the pharmacist.
- On our unannounced visit on the 14 May 2015, we reviewed the daily temperature monitoring records again. All temperatures, current, maximum and minimum were recorded as having been within the expected range. We were told that a new temperature monitoring device had been purchased after our announced visit.
- A pharmacy technician visited the hospital and undertook checks on stored medicines and stock levels twice each week. Monthly cleaning of the medicine storage areas was also undertaken. Additionally, a pharmacist visited the hospital monthly to undertake checks and audits of medicines, including controlled drugs and drugs held on the resuscitation trollies. Records of the visit were documented including drugs past their expiry date and monthly cleaning of the storage area.
- Robust processes and procedures were in place to ensure medicines for patients to take home were given appropriately and safely. This included labelling of medicines for individual patients and availability of leaflets so patients understood what their medicine was for and how to take it. Nursing staff advised and checked patients' understanding of their to take out (TTO) medicines before discharge.

Records

- Patient records were paper based. Four sets of outpatient's notes were reviewed during the inspection. All four sets of records were complete and included test results, consent forms, operation notes and copies of correspondence with GPs.
- Monthly audits of medical records took place to check that medical records contained the required information. Audits typically showed high levels of compliance above 90% however in December 2014 the audit results for nutrition and hydration were lower at 60%. Audit results returned to 98% and 99% respectively for January 2015 and February 2015. The nutrition and hydration audit was re-audited in January 2015 with a result of 100%.
- Medical records were stored securely in dedicated records cabinets which could be locked. These cabinets were located at the nursing station in the outpatient department which was seen to be continually staffed during the inspection. Medical records were not removed from the hospital by clinical staff, in accordance with the hospital's policy.
- Staff informed us patients were not seen by a consultant without their records being available.

Safeguarding

- Data from the hospital showed that there have been no safeguarding alerts or concerns during the last 12 months.
- The hospital had identified leads for safeguarding. Staff we spoke to had an awareness of who these leads were, how to identify safeguarding issues and what to do if they had any concerns.

Outpatients and diagnostic imaging

- Details of the safeguarding process and leads for safeguarding were located around the hospital on small laminated signs where staff and patients could see them. The hospital had a safeguarding policy in place which was reviewed in November 2014. This policy outlined the responsibilities of staff with regards to safeguarding.
- The hospital's mandatory training program included safeguarding adults as one of the elements and evidence was seen that 100% of staff had undertaken this training.
- 'Keeping people safe from abuse' information leaflets were located at various points around the hospital and were accessible to staff and patients.

Mandatory training

- The hospital delivered mandatory training using a combination of on-line electronic learning packages and face to face learning. Face to face learning took place once a year when the hospital was closed to patients. Staff not able to attend the day were asked to attend at another of the provider's locations to complete the learning. Elements included basic life support, infection control and health and safety, manual handling, fire safety and customer care.
- There was an expectation that all staff attended the face to face training and completed the required electronic learning courses.
- 100% of staff had completed their mandatory training during the 2014/2015 year.

Assessing and responding to patient risk

- Resuscitation equipment was available in the theatre and outpatient areas. All nursing staff and healthcare assistants had undertaken intermediate life support (ILS) training last year. All registered nurses had undertaken acute illness management training.
- During the inspection, we witnessed staff who responded rapidly to a cardiac arrest alarm triggered in error.
- The hospital had access to a radiation protection supervisor and radiation protection adviser in accordance with the ionising radiation (medical exposure) regulations (IR(ME)R 2000).
- A radiology world health organisation (WHO) checklist was used prior to the use of any radiological equipment. Additionally, consultants who requested radiological imaging were prompted to ask female patients who could have been pregnant about the possibility of pregnancy. Patient's responses to questions about whether or not they may be pregnant were recorded on the radiological image request form and reviewed by staff prior to the use of x-ray equipment.
- The hospital had radiological policies and procedures in place, including a set of local rules. Local rules set out the way in which diagnostic imaging was undertaken in accordance with national guidance.
- The hospital maintained a list of those clinicians and operators who were trained and authorised to use radiological imaging equipment and the clinicians who were authorised to request radiological images.
- The radiation protection supervisor conducted audits and produced risk assessments in accordance with the requirements of IR(ME)R 2000.

Nursing staffing

- Nursing staff in outpatients said there were sufficient staff on duty to provide safe and effective care to patients. This was supported by patients who told us they felt staff took sufficient time to discuss their care with them appropriately.
- There was one vacancy for a registered nurse at the time of inspection although staff did not indicate that this had caused operational difficulty or compromised the care delivered to patients.
- In the outpatients department there was a total of nine whole time equivalent (WTE) staff including a lead nurse, registered nurses and healthcare assistants.
- The ratio of nurse team leader to other nursing staff was approximately 1 to 3.4. The ratio of nurses not in a managerial role to healthcare assistants was approximately 1 to 0.8.
- There had been no use of agency staff to cover nursing or healthcare assistant posts between January and December 2014.
- The hospital had implemented a new rostering management system in March 2014. Patient activity levels and acuity were reviewed daily using this system, enabling flexibility of staffing in clinical areas to help plan for adequate staffing levels which were in line with National Institute for Health and Care Excellence (NICE) guidelines.

Medical staffing

- The hospital had sufficient doctors in the outpatient department. The hospital had 1.6 whole time equivalent

Outpatients and diagnostic imaging

(WTE) doctors who were directly employed. There were also 34 doctors working under practising privileges. Practicing privileges refers to medical practitioners being granted the right to practice within a hospital.
- The nursing staff reported there was very good access to medical staff when required and nursing and medical staff worked together well as a team when providing care and treatment.

Major incident awareness and training

- The hospital's business continuity plan included procedures to follow in the event of emergencies. These included medical emergencies and also other events such as problems with the building, fire and flood.
- On a six monthly basis, the provider gave certain scenarios to the hospital to use in a desk top simulated emergency exercise. This allowed the hospital staff to test simulations of potential emergencies and how their emergency procedures would work in a safe environment. As part of these exercises, any issues with emergency procedures could be highlighted and improvements identified as a result. The hospital had recently run desk top exercises covering flood and suspicious packages as two emergency scenarios.
- The hospital was not part of the local trust's major incident planning although the manager informed us the hospital would do all it could to support the trust if it were necessary.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Care delivered by the hospital was in accordance with National Institute for Health and Care Excellence (NICE) guidelines. Checks were undertaken at the hospital to monitor the care that was being delivered and identify areas for improvement. This was reviewed at clinical governance meetings.

Systems for appraising both medical and nursing staff were in place, in addition to training being available. Nursing staff reported that they had sufficient access to medical staff and could discuss patient related issues with them.

Records of consent that were reviewed were thorough and included details of the risks associated with the procedure. There were procedures in place should a patient lack the capacity to consent to treatment; staff demonstrated a good awareness of this.

Evidence-based care and treatment

- The hospital had policies and care pathways in place that were in line with national guidance.
- Staff involved in diagnostic imaging demonstrated an understanding of their role with regards to Ionising Radiation (Medical Exposure) regulations 2000 (IR(ME)R) and protecting patients from the risks of unnecessary exposure to x-rays.
- Diagnostic reference levels (DRLs) were used at the hospital. This is endorsed by professional bodies and is used to identify situations where the dose of radiation may be reduced without compromising the quality of the diagnostic image. These DRLs were also audited by the radiation protection supervisor as part of the hospital's audit programme.
- Medical staff told us National Institute for Health and Care Excellence (NICE) guidelines were reviewed at clinical governance meetings. Additionally, other guidelines were reviewed at the appropriate meetings such as joint advisory group (JAG) on gastrointestinal endoscopy being reviewed in the endoscopy user group's meetings.
- Local audits were undertaken at the hospital to monitor the care being delivered and identify areas for improvement. An example of improving a procedure was seen during the inspection where operating notes had been updated to include a dedicated space for clinicians to record both the date and time of a procedure. This change arose following an audit that showed although the date of the procedure was being recorded, the time was not. Subsequent audits showed compliance with recording dates and times on operating notes had increased following the introduction of the new operating notes.

Pain relief

- The hospital ran a pain clinic which supported patients in managing their pain relating to their conditions.
- Information was given to patients on rating pain and which explained the hospital's pain scoring system at the same time that the patient's appointment was sent out. This helped to inform patients on how to rate pain

so that pain levels could be discussed in outpatient clinics and following any procedure a patient may have undergone. The hospital used a visual pain scale which could be pointed to by patients having difficulty in communicating verbally to alert staff of their pain levels.
- Pain relief medication was given appropriately to patients following their procedure. To take out (TTO) pain relieving medication was also given to patients upon discharge if required. This was prescribed on an individual patient basis by the anaesthetist.
- The hospital's patient satisfaction survey for quarter four 2014 showed that 100% of respondents indicated that hospital staff did everything to control pain.

Patient outcomes

- Staff monitored patients following their outpatient treatments.
- Staff told us patients were contacted following outpatient treatments to check if patients had experienced any difficulties or complications following their treatment.

Competent staff

- The hospital had a system in place to ensure qualified nursing staff continued to maintain their registration. The hospital's newly implemented rostering system for nurses alerted the team leaders and manager when re-registration was due.
- Data provided by the hospital showed that at December 2014, 100% of both nursing and medical staff were appropriately registered with their professional body.
- Practicing privileges refers to medical practitioners being granted the right to practice in a hospital. Practicing privileges were granted or rejected by the provider's Medical Advisory Committee. In order to assess a consultant's suitability to practice at the hospital, the provider undertook checks on qualifications, reviewed references and disclosure and barring with the Disclosure and Barring Service (DBS).
- Medical staff working under practising privileges and who undertook clinical work in the NHS received annual appraisals through their employing trust's processes. Copies of these appraisals were provided to the hospital and were reviewed by the Matron and the chair of the hospital's Medical Advisory Committee. Those medical staff who did not work in an NHS trust were appraised by a senior member of medical staff practising in the same speciality from within the provider's healthcare group.
- The hospital had processes in place to address any issues with consultant competence whether the consultant was employed by the hospital directly or worked under practising privileges. The hospital manager told us there had been no competence issues with any of the consultants working at the hospital.
- All new staff at the hospital underwent a two week induction when they started work at the hospital.
- New staff worked in addition to the required staffing numbers until their competency had been assessed and approved by senior members of staff. This helped to ensure that only qualified members of staff worked at the hospital.
- The hospital was also offering an apprenticeship for a healthcare assistant who was additionally being supported by a training college.
- Staff directly employed by the hospital all received annual appraisals. Medical staff were appraised by a senior member of medical staff practising in the same speciality from within the provider's healthcare group. Nursing staff were appraised by their line managers. Data provided by the hospital showed that 100% of nursing and healthcare assistant staff had received an appraisal in 2014.

Multidisciplinary working

- Staff reported that they felt the smaller size of the hospital allowed them to get to know each other and work well together as a team.
- Nursing staff reported they had sufficient access to medical staff and could discuss patient related issues with them.
- X-ray images or MRI scans of patients taken outside of the hospital were available to medical staff at the hospital. Diagnostic images taken at other hospitals in the provider's group were available electronically. Images taken at a nearby NHS trust hospital were saved to a computer disk which could be reviewed in clinics by the medical staff.
- If a patient's procedure indicated there may be signs of cancer present, for example, following an endoscopic investigation we were told that a thorough

multidisciplinary team meeting would take place. This meeting would include medical staff from the hospital and the NHS trust where the patient would be referred to for ongoing treatment and care.
- A physiotherapist from another of the provider's hospitals attended the hospital once per week to deliver care to patients requiring physiotherapy services.

Seven-day services

- The hospital's opening times were typically 7.30am to 8pm Monday to Saturday.
- Staff told us outpatient services were provided dependent on the types of clinic required and the numbers of patients who required an outpatient appointment.

Access to information

- Hospital staff received medical information regarding patients from their GP as part of their referral process via the 'choose and book' system. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
- Medical staff had access to x-ray and other medical images either through an electronic portal or by viewing images that had been saved to a computer disk.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During the inspection we looked at four sets of patient's medical records to see if consent to treatment had been obtained. In all four cases consent had been sought and was documented in the records. The details of the recorded consent were thorough and included details of the risks associated with the procedure.
- The provider had a policy in place covering the seeking of consent. This policy included details on ensuring that a patient had the capacity to consent and how to proceed if they did not.
- Nursing staff told us that if they had concerns about a patient's capacity to consent or make informed choices, they would alert the patient's consultant. Consultants undertook mental capacity assessments when it was thought appropriate to do so and would make a best interest decision for the patient if necessary. If required, both mental capacity assessments and any best interest decisions were recorded in the patient's medical notes.

Are outpatient and diagnostic imaging services caring?

Good

Patients' treatment had been explained to them and they felt the care delivered had not been rushed. During the inspection we saw patients were treated with dignity and respect by the hospital staff. Patients told us how they were supported by hospital staff during their appointments. The hospital's patients survey data showed 95% and 90% of outpatients in January 2015 and February 2015 respectively would recommend the hospital to their family and friends. The hospital did not use NHS Friends and Family Test because it used its own patient surveys.

The hospital's friends and family test equivalent data showed that the majority of patients would recommend the hospital to family or friends as a place to receive treatment.

Compassionate care

- During the inspection we saw patients being treated with dignity and respect by the hospital staff.
- Three patients we spoke with during the inspection all spoke very highly of the care they had received. Patients told us staff always introduced themselves when speaking with them, they made time to speak with them and the care provided did not feel rushed.
- The hospital's patients survey data showed 95% and 90% of outpatients in January 2015 and February 2015 respectively would recommend the hospital to their family and friends. The hospital did not use NHS Friends and Family Test because it used its own patient surveys.

Understanding and involvement of patients and those close to them

- Patients we spoke with reported they understood their treatment, which had been explained to them. Patient information leaflets also included information which patients could take away with them to review.
- The consent forms that were reviewed as part of an audit of medical records detailed the risks associated with a particular procedure.

Outpatients and diagnostic imaging

Emotional support

- One patient told us they had been very nervous about the procedure they were attending the hospital for. They described how the consultant had taken time to explain the procedure fully and the plan for what would happen afterwards. The patient also explained while waiting for the procedure in the pre-theatre bay, they had never been left alone and a nurse had taken the time to stay with them. This helped the patient to feel they and their care were important to the hospital and also to feel secure.
- Patients had access to support via a 24 hour telephone service. During the inspection we observed a member of the nursing staff respond to a call via the 24 hour help line. The nurse gave advice to the patient on how the patient should care for their surgical site, spending sufficient time with the patient to go over the care and check the patient felt they had the required information.

Are outpatient and diagnostic imaging services responsive?

Good

The hospital had measures in place to support patient's differing needs, such as access to interpreters via a telephone interpretation service. The hospital had trained two members of staff to work as dementia champions so they could advise other staff on how best to support people living with dementia.

Between October 2014 and February 2015, 100% of patients were seen within the 18 week referral to treatment target. The hospital had sufficient seating and space in the waiting area and there were drinks available for patients. There was a free car park available for use by patients or those bringing them to appointments. Patients had access to support via a 24 hour telephone service through which they could ask questions about their treatment or seek support for any concerns they may have regarding their condition.

The hospital had a complaints procedure in place for investigating complaints, responding to the complainant and learning from complaints. Complaints were discussed in governance meetings so learning could be shared and procedures or practices improved.

Service planning and delivery to meet the needs of local people

- The environment in the hospital was comfortable for patients and those close to them. There was sufficient seating for patients in the waiting area. There was a vending machine in the waiting area where patients could get drinks if they wished.
- There was free car parking available on site.
- Appointment letters included useful information and advice for patients such as a leaflet about the hospital including how to find it and details of the patient's consultant. For some patients, additional information was included. Patients awaiting an ophthalmic procedure for example were told they should bring someone with them to the appointment to help them get home afterwards as their visit may include the use of certain eye drops which could temporarily affect their vision.
- We were told some medical staff seeing ophthalmology outpatients were able to offer same day appointments for a procedure to patients with certain eye conditions following their initial consultation. These appointments were not mandatory and some patients preferred to review the information received during the first consultation before deciding upon their treatment options.

Access and flow

- The national standard for referral to treatment (RTT) time states that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. Data provided by the hospital showed that between October 2014 and February 2015 100% of patients were seen within this 18 week target.
- The hospital received weekly reports from the provider which listed patient waiting times and helped to identify any patients who may be about to breach the 18 week target. If any patients were to breach the 18 week target, we were told that administration staff would review the appointments to identify the causes of the breach and to identify any improvements that could be made to reduce the number of further breaches.
- The hospital did not see patients referred by their GP with suspected cancers and therefore the national cancer plan's two week target for a patient to be seen by a doctor following referral did not apply.

Outpatients and diagnostic imaging

- Appointments for surgical procedures were routinely made on the same day as the patient saw the consultant at their initial outpatient appointment.
- We were told patients waiting for endoscopies were usually seen within two to four weeks of referral and the hospital achieved the six week waiting time target for endoscopic procedures. If reviews of patients waiting for endoscopic procedures showed patients may exceed the six week wait target, extra endoscopy clinics were arranged to ensure the target was not missed.
- The hospital reported that long waiting times for patients once they arrived for their appointments was not an issue and therefore had no data on average waiting times at the hospital. We observed during our inspection that patients did not have excessively long wait times for their appointments.
- If clinics were running late and patients were having to wait longer than anticipated once they arrived at the hospital, reception staff informed them of this on arrival. If a patient did not wish to or could not wait, an alternative appointment date was booked. Updates on waiting times were given to patients by nursing or reception staff verbally if clinics were delayed. Staff told us they did not routinely monitor if patients' appointments were delayed or unavailable because these were rare occurrences.
- Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Patients we spoke to did not report any problems with the booking of their initial appointment and two patients indicated they had actively chosen the hospital based upon the positive experiences of friends and family at the hospital.
- One patient told us that an appointment needed to be rebooked as one of the hospital's machines had broken and was being replaced. The patient explained they had chased up the appointment and had not received as much information about the new appointment as they may have expected. The appointment was however rebooked and the patient later received confirmation through the post. Despite the issues while booking the appointment the patient was very complimentary about the staff, how they cared for the patients and had no complaints.

Meeting people's individual needs

- Patients had access to support via a 24 hour telephone service through which they could ask questions about their treatment or seek support for any concerns they may have regarding their condition.
- Information leaflets were available to patients regarding their treatment which patients could take away with them.
- Information leaflets given to patients were in English only. However staff told us in the past, the vast majority of patients for whom English was not their first language still requested English language information leaflets.
- Access to interpreters was available to hospital staff via an over the phone interpretation service. Interpretation services could be accessed by all staff during nurse assessment clinics, outpatient consultations and on the day of any procedure the patient may have. In the case of patients requiring interpretation services prior to a procedure, patients would be listed at the beginning or end of a surgical list. This allowed the clinician and the anaesthetist to leave theatres and join the interpretation telephone call meaning any questions the patient may have had for either clinician could be asked and answered during the call.
- Signs informing patients they were entitled to take a chaperone to their consultation were on display in patient areas and in the treatment/consultation rooms. Patients however were not made aware of this prior to attending the hospital which meant that they may not have brought a particular chaperone with them. The hospital had recently implemented a policy where all patient consultations had a second member of staff present to act as a chaperone.
- The hospital had two members of staff who had been trained as dementia champions. The two champions cascaded relevant information on dementia to other hospital staff to increase their awareness.
- All patients over 75 years of age underwent a dementia screening process. Where some level of dementia was indicated a more thorough dementia test was undertaken and if necessary, a referral made back to the patients' GP so that it could be followed up.
- The hospital had undertaken a review of adaptations which may help patients with dementia. Although not

all of the adaptations had been completed at the time of the inspection, examples of adaptations that had been made included new signage for toilets which used pictures and contrasting coloured toilet seats.
- Staff told us privacy curtains in the pre-theatre and recovery areas were closed when patients occupied the bays. A private room with a door was also available in the recovery area for staff to speak with patients in private if requested by a patient or if patients were being given bad news.

Learning from complaints and concerns

- 'We value your opinion' and 'How to make a complaint' leaflets were visible and available to patients throughout the hospital. Staff were aware of the complaints policy and were able to advise patients on the complaint procedure if necessary.
- If a patient had a concern, hospital staff firstly tried to resolve the issue at the time for the patient. If however the complaint was not resolved, then a formal complaint could be made by the patient.
- Complaints were recorded on the hospital's electronic risk system. The hospital had a procedure in place for investigating complaints, responding to the complainant and learning from complaints.
- During the inspection we were given an example of a complaint that was made and told about how it was investigated and how procedures had been changed as a result. Evidence of this was seen in the minutes of the hospital's senior management team meeting and the clinical governance meeting. This showed that suitable governance procedures were in place to facilitate investigating and learning from complaints.

Are outpatient and diagnostic imaging services well-led?

Good

Staff were aware of the cultural ethos called 'The Ramsay Way' which amongst other values, placed an emphasis on providing caring treatment for patients. Staff described a positive and supportive culture that encouraged them to learn and develop either through a combination of in-house or external learning opportunities. Staff felt supported by management. Feedback from patients was encouraged and when feedback rates had dropped, initiatives were put in place to increase it. Staff feedback was also sought through staff surveys and a staff forum.

Governance meetings took place at the hospital and reviewed audit work that was undertaken, complaints and risks in addition to other areas so that oversight of the care received by patients was maintained.

The hospital's management were aware of the limitations of the premises due to their size and were considering plans on how reconfiguration of the hospital may improve and expand the services offered at the hospital.

Vision and strategy for this core service

- The provider had a vision and cultural ethos which it called 'The Ramsay Way'. This included elements such as; being caring, enjoying work, being of positive spirit, continuously seeking ways of doing things better and encouraging the value of people and teams.
- 'Ramsay Way' signs and information were displayed on notice boards throughout the hospital.
- Staff knew about the 'Ramsay Way' and the emphasis on providing caring treatment for patients, which was always discussed at staff meetings. Staff were able to talk to us about the provider's vision.

Governance, risk management and quality measurement for this core service

- The hospital held a variety of meetings through which governance issues were addressed. The meetings included senior management, clinical governance committee, infection prevention and control, health and safety and medical advisory committee. Other speciality meetings also took place for example, the endoscopy group meetings.
- The chair of the hospital's medical advisory committee also sat on the provider's regional committee which facilitated the transfer of information from the provider to the hospital.
- The hospital maintained a risk register which included a variety of risks including for example, financial, clinical and patient care risks. Outpatient related risks were recorded and managed appropriately.
- There was a schedule of audits which were undertaken by nursing staff on a rotational basis. Results of the audits were reviewed at relevant meetings and

processes changed to address issues that had been highlighted. Examples of audit topics included anaesthetic standards, medical records, consent, pre admission/discharge and medicines management.
- We saw evidence in meeting minutes of complaints being discussed at the hospital's senior management team meeting and the clinical governance meeting.
- Commissioning for quality and innovation (CQUINs) set by the clinical commissioning groups were monitored by the hospital manager. We saw all CQUINs for 2014 had been achieved by the hospital in 2014.
- The hospital had recently implemented the idea of clinical champions who took responsibility for aspects of clinical care and for sharing knowledge within the teams working at the hospital.

Leadership of service

- All staff talked positively about working at the hospital.
- Senior staff reported that management were responsive to requests and suggestions. For example, where a case had been made that more nursing or healthcare staff were needed this was supported by management and staff were recruited.

Culture within the service

- Staff spoke very highly about working at the hospital. They described a positive and supportive culture that encouraged staff to learn and develop either through in-house or external learning opportunities.
- The hospital matron worked closely with staff and knew all of the staff working at the hospital. At busy times or if cover was needed at short notice, the hospital matron would also undertake nursing duties to help reduce the workloads of other nursing staff.

Public and staff engagement

- The hospital undertook bi-annual staff surveys. Following feedback from staff through these surveys, action plans were developed to address issues that had been raised. Feedback from consultant staff was through informal routes however the hospital had plans to formalise this feedback mechanism.
- The hospital had a staff forum. The types of staff forum meetings changed between full meetings and smaller, 'micro' meetings with the aim of increasing staff engagement and access to meetings.
- The hospital had a formal patient participation group which gave feedback from a patient perspective.
- The hospital sought feedback from all patients via its feedback mechanisms and surveys. Feedback rates were monitored and we were shown examples where feedback rates had dropped. Where this had occurred we were told that initiatives to remind patients about the importance of feedback were put in place and subsequently, feedback rates had improved.

Innovation, improvement and sustainability

- The hospital's management were aware of the limitations of the premises due to their size. Plans were under consideration to reconfigure the hospital layout which would mean a second theatre, more outpatient clinic rooms and recovery areas would be created.
- Through the hospital's audit program, procedures and processes were being continually reviewed and updated to make improvements for example, we saw operating record sheets which had been amended in order to improve the information recorded.

Outstanding practice and areas for improvement

Outstanding practice

- 100% of staff had completed all mandatory training and appraisals in 2014/15.
- The hospital had been awarded accreditation by the Joint Advisory Group (JAG) on gastrointestinal endoscopy and was the first independent hospital to achieve this.
- The hospital operated a 24 hour telephone helpline run by hospital staff, available to all patients post procedure or operation.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should ensure specialist personal protective equipment (PPE) in radiology, including lead aprons, are checked regularly.
- The provider should ensure requests to repair equipment are made, recorded and completed using standard processes and procedures.