North Downs Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection of North Downs Hospital on the 17 and 18 May and 1 June 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical services and outpatients and diagnostic services as these incorporated the activity undertaken by the provider, Ramsay Health Care UK Operations Limited, at this location.

We did not inspect a private GP service which operates at this location as this is a service from another provider. Physiotherapy services at this location were provided from a third party on a contract basis to the location, and likewise were not inspected.

We rated the both core services, and the hospital as good overall. However, we found that safety in the outpatient department required improvement because we had concerns about the suitability of the environment and had insufficient assurance in relation to the maintenance and use of some equipment.

Are services safe at this hospital?

We found improvements were required to minimise risks and promote safety.

- In the outpatient department, we found that the clinical environment did not meet national guidelines, for example in the design of sinks or floor coverings which could lead to ineffective prevention of infection.
- We also found that in this department there were insufficiently robust systems to maintain and calibrate equipment in use.
- There were insufficiently robust systems for control of prescription pads to prevent potential mis-use. Medical gases were not securely stored.
- We also found that mandatory training rates in some topics were below 50% in all departments so the provider could not be assured of the skills and competence of staff providing care. The hospital did not have systems to be assured of the qualifications of external staff working as first assistants.

However, we also found:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff.
- Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.
- There were arrangements to transfer patients whose care needs exceeded what the hospital could safely provide, and saw that staff used these processes when patients' conditions required this.
- We found suitable medical cover at all times from a resident medical officer and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues.
- There were sufficient numbers of nursing and support staff to meet patients' needs.
- We saw there were efficient and effective methods for the handover of care between clinical staff.
- There was a designated lead for safeguarding vulnerable adults and staff were trained appropriately to recognise and report suspected abuse in vulnerable adults.

Are services effective at this hospital?

- We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice.
- There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance forums at the hospital.
- Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes and the hospital participated in relevant national audits and benchmarking activities.
- Patient outcomes were good when benchmarked against national standards. There were no concerns regarding rates of unplanned admission, return to theatre or transfer to another hospital.

Summary of findings

- We found arrangements that ensured that doctors and nurses were compliant with the revalidation requirements of their professional bodies. All consultants had clear practising privileges agreements which set out the hospitals expectations of them, and ensured they were competent to carry out the treatments they provided.
- Systems for obtaining consent were compliant with legislation and national guidance, including the Mental Capacity Act (2005) and these were adhered to by staff.

Are services caring at this hospital?

- We observed that patients were treated with dignity and respect and their privacy was maintained.
- We saw that staff offered appropriate emotional support.
- Patients who share their views said they were treated well, with compassion, and that their expectations were exceeded.
- We saw that results of the friends and family test and other patients satisfaction surveys demonstrated that patients would recommend the hospital to others.

Are services responsive at this hospital?

- Services were planned to meet the needs of patients.
- We saw that some services operated in the evenings and at weekends to give patients flexible access to these services.
- We saw examples of systems to support patients living with dementia and learning difficulties. The environment allowed for patients with physical disabilities to be safely cared for.
- The hospital was exceeding national referral to treatment time standards.
- Patients were assessed prior to admission to ensure that hospital could safely meet their needs.
- There was a robust complaints procedure, which was well publicised and understood by staff. Complaints were investigated, actions taken to resolve issues and there was learning evident from the content of complaints.

Are services well led at this hospital?

- We found that staff were conversant with the corporate vision and values and strove to demonstrate these in their daily work.
- There was an appropriate system of governance and mangers knew the key risks and challenges to the hospital and were taking steps to mitigate the impact of these.
- However, the management team had limited understanding of the Workforce Race Equality Standard (WRES) despite this being a national requirement, and were yet to consider how this would be implemented locally.
- Practising privileges were received, authorised and granted in conjunction with the Medical Advisory Committee and kept under review.
- There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams.
- The provider was responsible for ensuring that those in director level roles fulfilled the fit and proper person test.
- Managers were aware of the need to develop their service and to ensure its sustainability by responding to new markets.
- We saw examples of initiatives that were introduced to improve patient experience and to ensure the safety and quality of care kept pace with new developments and growing expectations.

Our key findings were as follows:

- There were adequate systems to keep people safe and to learn from critical incidents.
- The hospital environment was visibly clean and well maintained and there were measures to prevent the spread of infection.
- There were systems to ensure the safe storage, use and administration of medicines.

Summary of findings

- There were adequate numbers of suitably qualified, skilled and experienced staff (including doctors and nurses) to meet patients' need. There were arrangements to ensure staff had and maintained the skills required to do their jobs.
- There were arrangements to ensure people received adequate food and drink that met their needs and preferences.
- Care was delivered in line with national guidance and the outcomes for patients were good when benchmarked.
- Robust arrangements for obtaining consent ensured legal requirements and national guidance were met.
- The individual needs of patients were met including those in vulnerable circumstances such as those learning disability or dementia.
- Patients could access care when they needed it.
- Patients were treated with compassion and their privacy and dignity were maintained.
- The hospital was managed by a team who had the confidence of patients and their teams. Staff felt motivated by the management team.
- There was appropriate management of quality and governance at a local level and managers were aware of the risks and challenges they needed to address.

There were also areas of where the provider needs to make improvements.

Importantly, the provider must:

- Improve compliance with its mandatory training programme.
- Ensure first assistant have the necessary skills and competence to carry out their roles.
- Store medical gases securely, and have systems to minimise the mis-use of prescription pads.

In addition the provider should:

- Carry out planned works without delay to ensure clinical areas comply with Health Building Note (HBN) 00/10 Part A Flooring (DH 2013).
- Consider the controls in place for the monitoring and provision of prescription slips in the outpatient department to ensure they are sufficiently robust.
- Review the arrangements for Portable Appliance Testing it ensure it is consistent and that all relevant electrical items carry a certificate of testing notice.
- Assess the risks of the use of oxygen cylinders and the absence of piped medical gases.
- Consider the arrangements that ensure the completion of action points following learning from an incident.
- Review the use of latex gloves in theatres.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Good**	• There were arrangements to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and they were fully supported when they did. • Departments performed frequent audits and acted upon results. The leadership team understood what the challenges to safety were and took action to address them. • Medicines were appropriately stored and checked in line with legal requirements except for medical gas cylinders which were not always securely stored. The general environment was visibly clean and a safe place to care for surgical patients • Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. • Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. Staff were supported to maintain and develop their skills and were passionate about working at the hospital. • Patients had good outcomes. Outcomes were monitored and reviewed to ensure care was evidence based and adhered to best practice guidance. Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes. • Staff delivered care that exceeded patients' expectations. It was easy for people to complain or raise a concern and they were treated compassionately when they did so. • Mandatory training rates were below those expected by the organization. The hospital could not be assured of the competence and qualifications of first assistants.

Summary of findings

Outpatients and diagnostic imaging

Good

- There were systems to keep patients safe, including the reporting and investigation of incidents.
- Staffing levels were sufficient to meet the needs of patients and we observed effective multi-disciplinary working by competent staff.
- Staff were enthusiastic and caring and we observed positive interactions between staff and patients. All patients spoke highly of the care they had received regardless of how they were referred or funded.
- There were arrangements to ensure that the individual needs of patients were met, for example interpreters could be booked for patients and the hospital was wheelchair accessible.
- There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams. There was appropriate management of quality and governance at a local level.
- However, we also found the clinical environment did not meet national guidance, for example the use of inappropriate floor coverings.
- There was insufficient assurance in relation to the maintenance or calibration of equipment and insufficient controls in place to prevent the misuse of prescription forms.
- Mandatory training rates were below those expected by the organization.

Summary of findings

Contents

Good

North Downs Hospital

Services we looked at

< Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to North Downs Hospital

North Downs is an independent hospital which is part of Ramsay Health Care UK Operations Limited. The hospital has 18 in-patient and five day-case beds and two theatres. It is situated in Caterham, Surrey in a residential area which does not have any appreciable levels of social depravation.

The registered manager designate was Monica Clarke. Ms Clarke had submitted an application to be registered manager and we were processing this application at the time of our inspection. The provider's nominated individual for this service was Vivienne Heckford. The controlled Drug Accountable Officer was Carole Collier.

Our inspection team

Our inspection team was led by:

Inspection Lead: Shaun Marten, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

- A radiographer
- A consultant surgeon
- Two nurses including a theatre nurse and one with experience of managing independent hospitals

Why we carried out this inspection

We inspected this hospital as part of our national programme to inspect and rate all independent healthcare providers. We inspected two core services at the hospital which incorporated all the activity undertaken. These were Surgical services and Outpatient and Diagnostic Services.

How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We requested information from the local clinical commissioning group. We placed comment boxes at the hospital prior to our inspection which enabled staff and patients to provide us with their views. We received 33 comments from patients and 10 from staff.

We carried out an announced inspection on the 17 and 18 May 2016 and an unannounced visit on the 1 June 2016.

We held two focus groups where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee. We spoke with a wide range of staff including nurses, resident medical officer, radiographers and administrative and support staff totalling 62 personnel.

We also spoke with 19 patients who were using the hospital.

We observed care in the outpatient and imaging departments, in operating theatres and on the wards and reviewed patient records. We visited all the clinical areas at the hospital.

Summary of this inspection

Information about North Downs Hospital

During 2015, North Downs Hospital treated a total of 822 patients requiring overnight stays and 3,086 day cases. Of the day inpatient stays 76% were NHS funded as were 73% of day cases. In addition, the hospital saw 19,342 outpatient attendances of which 57% were NHS funded.

In 2015, the most common surgical procedures performed were colonoscopy (333), knee arthroscopy (208), oesophago-gastro duodenoscopy (OGD) (261) and cataract surgery (199).

There were 128 doctors with practising privileges at the hospital, and 42% of these carried out over 100 procedures during 2015, Only 17 did not carry out any procedures during the same period. There were 25 registered staff employed, including nurses, and 46 support staff including care assistants and administrative staff. There were high levels of staff stability during 2015, at over 80%, and staff turnover was low at less than 20%.

Sickness rates were less than 10%. Although there were low vacancy levels for most staff, there were high vacancy rates for nurses working in the in-patient areas at greater than 20%.

During 2015 we did not receive any direct complaints or whistle-blowing contacts. The hospital received a total of 61 complaints, an increase on the previous two years.

During 2015 there were no serious incidents or never events at the hospital. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. There were 151 other clinical incidents within this year. The overall rate of clinical incidents (per 100 inpatient discharges) fell in the same period. No safeguarding concerns have been reported since January 2015.

In the same year there were no unexpected deaths and no were no reported cases of serious infection such as MRSA.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We found improvements were required to minimise risks and promote safety.

- In the outpatient department, we found that the clinical environment did not meet national guidelines, for example in the design of sinks or floor coverings which could lead to ineffective prevention of infection.
- We also found that in this department there were insufficiently robust systems to maintain and calibrate equipment in use.
- There were insufficiently robust systems for control of prescription pads to prevent potential mis-use. Medical gases were not securely stored.
- We also found that mandatory training rates in some topics were below 50% in all departments so the provider could not be assured of the skills and competence of staff providing care. The hospital did not have systems to be assured of the qualifications of external staff working as first assistants.

However, we also found:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff.
- Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.
- There were arrangements to transfer patients whose care needs exceeded what the hospital could safely provide, and saw that staff used these processes when patients' conditions required this.
- We found suitable medical cover at all times from a resident medical officer and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues.
- There were sufficient numbers of nursing and support staff to meet patients' needs.
- We saw there were efficient and effective methods for the handover of care between clinical staff.
- There was a designated lead for safeguarding vulnerable adults and staff were trained appropriately to recognise and report suspected abuse in vulnerable adults.

Summary of this inspection

Are services effective?

Good

- We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice.
- There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance forums at the hospital.
- Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes and the hospital participated in relevant national audits and benchmarking activities.
- Patient outcomes were good when benchmarked against national standards. There were no concerns regarding rates of unplanned admission, return to theatre or transfer to another hospital.
- We found arrangements that ensured that doctors and nurses were compliant with the revalidation requirements of their professional bodies. All consultants had clear practising privileges agreements which set out the hospitals expectations of them, and ensured they were competent to carry out the treatments they provided.
- Systems for obtaining consent were compliant with legislation and national guidance, including the Mental Capacity Act (2005) and these were adhered to by staff.

Are services caring?

Good

- We observed that patients were treated with dignity and respect and their privacy was maintained.
- We saw that staff offered appropriate emotional support.
- Patients who share their views said they were treated well, with compassion, and that their expectations were exceeded.
- We saw that results of the friends and family test and other patients satisfaction surveys demonstrated that patients would recommend the hospital to others.

Are services responsive?

Good

- Services were planned to meet the needs of patients.
- We saw that some services operated in the evenings and at weekends to give patients flexible access to these services.
- We saw examples of systems to support patients living with dementia and learning difficulties. The environment allowed for patients with physical disabilities to be safely cared for.
- The hospital was exceeding national referral to treatment time standards.

Summary of this inspection

- Patients were assessed prior to admission to ensure that hospital could safely meet their needs.
- There was a robust complaints procedure, which was well publicised and understood by staff. Complaints were investigated, actions taken to resolve issues and there was learning evident from the content of complaints.

Are services well-led?

Good

- We found that staff were conversant with the corporate vision and values and strove to demonstrate these in their daily work.
- There was an appropriate system of governance and managers knew the key risks and challenges to the hospital and were taking steps to mitigate the impact of these.
- However, the management team had limited understanding of the Workforce Race Equality Standard (WRES) despite this being a national requirement, and were yet to consider how this would be implemented locally.
- Practising privileges were received, authorised and granted in conjunction with the Medical Advisory Committee and kept under review.
- There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams.
- The provider was responsible for ensuring that those in director level roles fulfilled the fit and proper person test.
- Managers were aware of the need to develop their service and to ensure its sustainability by responding to new markets.
- We saw examples of initiatives that were introduced to improve patient experience and to ensure the safety and quality of care kept pace with new developments and growing expectations.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Information about the service

Surgical services at North Downs hospital consists of 18 overnight beds, five day care beds and two operating theatres. The overnight beds are all single en-suite rooms, with the exception of one room which accommodates two patients. Patients are admitted to the day surgery unit on the day of surgery and go to the theatre complex for their procedure and return to the day surgery unit to recover and are then discharged home. Only adults were treated at North Downs hospital.

The theatre complex comprises of two theatres, one anaesthetic room which is shared between both theatres and a three bedded recovery unit.

Theatre one was open during the hours of 8 am until 8 pm and has laminar flow (a system that circulates filtered air which reduces the risk of airborne contamination). The procedures undertaken in this theatre include orthopaedics, gynaecology, plastics/ cosmetics, general surgery, ophthalmic, urology and ear nose and throat (ENT) Theatre two is open during the hours of 8 am until 8 pm and does not have laminar flow. The procedures undertaken in theatre two are similar to theatre one with the exception of orthopaedics and the addition of endoscopy (examination of the inside of the body by using a lighted, flexible instrument called an endoscope).

There were 3,844 visits to the theatre between January 2015 -December 2015. The five most common procedures performed were:

• Colonoscopy (flexible tube (colonoscope) inserted into the rectum) (333)

• Knee arthroscopy (looking inside the knee with a camera) (268)

• Oesophago-gastroduodenoscopy (looking inside the stomach) (OGD) (261)

• Cataract (removal of the natural lens of the eye) (199)

• Hip replacement (166)

The majority of the procedures undertaken were NHS funded (75%)

During our inspection, we visited all inpatient areas of the surgical services. We observed care being delivered in a variety of care settings. We spoke to 15 patients and 44 members of staff during our inspection.

We reviewed data and a variety of information supplied to us prior to and during the inspection. We received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection. We also reviewed the hospital's performance data.

During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service.

Good

Surgery

Summary of findings

Overall, we rated surgical services at North Downs Hospital a good. This was because:

- Departments performed frequent audits such as the theatre checklist and hand hygiene and acted upon results.
- The general environment was visibly clean and a safe place to care for surgical patients.
- Medicines were appropriately stored and checked in line with legal requirements.
- We found there were arrangements to ensure that staff were competent and confident to look after patients. Mechanisms were in place to support staff and promote their positive wellbeing.
- Staff were supported to maintain and further develop their professional skills and experience, and were passionate about working at the hospital.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and they were fully supported when they do so. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. Any staff shortages were responded to quickly and adequately.
- Patients had good outcomes. Outcomes were monitored and reviewed to ensure care was evidence based and adhered to best practice guidance. Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes.
- Staff delivered care that exceeded patients' expectations.
- It was easy for people to complain or raise a concern and they were treated compassionately when they did so.
- The leadership team was knowledgeable about quality issues and priorities and understood what the challenges were and took action to address them.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

However:

- Investigation reports did not contain action logs to identify when requires actions were completed.
- Medical gas cylinders we not stored securely.
- There was poor compliance with mandatory training.
- The competence, capability and indemnity insurance cover of the surgical assistants could not be assured.

Good

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Root cause analysis investigation reports did not contain action logs
- Medical gas cylinders we not stored securely, and piped oxygen was not available.
- There was poor compliance with mandatory training.

However we found,

- People are protected from avoidable harm and abuse.
- Openness and transparency about safety was encouraged. Lessons were learnt and communicated widely to ensure improvement in other areas in addition to the services that were directly affected.
- Safety incidents such as infection control issues, slips, trips and falls were monitored throughout the service and opportunities to learn from external safety events were identified.
- There was sufficient emergency resuscitation equipment available and we saw evidence of equipment check log books.
- The surgical records and medical notes we reviewed were fully completed and were of a high standard.
- Surgical activity was monitored and reviewed to ensure staff were able to understand risks, and had a clear, accurate and current picture of safety.
- There were clearly defined and embedded systems, processes and standard operating procedures in place to keep people safe and safeguarded from abuse.
- There were effective handovers and safety briefings, to ensure staff could communicate and minimise risk to patients

Incidents

- Reviewing incidents was a standard agenda item on the quarterly clinical governance meetings and we saw evidence of this from meeting minutes. This ensured any themes of incidents were highlighted and new incidents discussed. There were a total of 26 safety incidents reported during the period October 2015 – December 2015 in surgical services.
- Patient post-operative infection the most commonly reported category of incident, accounting for 15% of incidents. The second most commonly reported category was related to medical records for example incorrect patient labels being placed in records. This accounted for 12% of incidents. This meant there was a risk that the patient details could be applied to information that did not relate to them and this could result in confusion or misdiagnosis.
- Hospital policy stated that incidents should be reported through the hospital electronic reporting system. All the staff we spoke to stated that they were encouraged to report incidents.
- Staff described the process for reporting incidents and told us they received feedback which was disseminated by email, ward meetings and safety briefings.
- The hospital reported one serious injury during the period January 2015 – December 2015 which involved a small piece of a disposable instrument breaking off during surgery and was subsequently retained. The hospital undertook a thorough investigation, and placed the remaining disposable instruments into quarantine and contacted the manufacturer. We saw evidence that there was and open and transparent conversation regarding the incident with the patient. This incident did not meet NHS England's criteria for a never event. as the fragment was known to be missing prior to the end of the operation and further action to locate or retrieve the fragment would be impossible or be more damaging than retention.
- Staff told us if things went wrong it was used for learning and they were treated fairly and respectfully.
- If staff were involved in incidents they were encouraged to write a reflective account of it which was discussed with their manager.
- We saw root cause analysis investigations (RCA) were completed as part of the investigation of incidents. We reviewed some examples of RCA's, lessons learned had been identified however there was no action logs for completion when identified learning actions had been completed. This meant actions to safeguard patients were not monitored to prevent a reoccurrence.
- There had been no reported never events between January 2015 – December 2015. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, never event reported could indicate unsafe practice.)

Duty Of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the organisation to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We saw that the hospital had a duty of candour policy and that staff were aware of the terminology, the process they described in communicating with patients and their relatives reflected openness and transparency.
- The hospital's electronic reporting system included prompts to ensure duty of candour obligations were undertaken. The hospital kept appropriate records of incidents that had triggered a duty of candour response and we saw a sample of these.

Safety thermometer

- The Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins).
- Data from the safety thermometer showed there were two incidents of hospital acquired Venous Thromboembolism (VTE) or Pulmonary embolism (PE) during the period January 2015 – December 2015.There were no new pressure ulcers, catheter or urinary tract infections.
- The VTE screening rate target of 95% for each quarter was consistently achieved for period January 2015 – December 2015.

Cleanliness, infection control and hygiene

- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile, between January 2015 - December 2015.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. In the PLACE audit 2016 North Downs hospital scored 91% which is better than the national average of 90% in relation to the cleanliness and general building maintenance of the hospital.
- There were infection prevention and control policies and procedures in place that were readily available to staff on the hospital's intranet and infection prevention and control was included in mandatory training programme and 100% of staff were up to date with this training.
- We saw an annual infection prevention plan 2016 which was reviewed quarterly and contained action points which were monitored through the head of department meetings and clinical governance committee meetings.
- We saw from meeting minutes that infection prevention and control report was a standard agenda item on the quarterly clinical governance committee meetings.
- Areas we visited were tidy and visibly clean, however, in theatres we found there were some concerns relating to infection prevention. In theatre one some of the walls and corners were in a bad state of repair which meant they could not be cleaned effectively and could pose an infection control risk. One storage trolley in theatres had a rusty top and wheels, which meant it could not be cleaned effectively and posed a potential infection control risk. The sluice room in theatres was clean and tidy however there were boxes on the floor which could become soiled if the floor became wet.
- We saw records of regular infection prevention and control audits that took place in order to ensure all staff were compliant with the hospital's policies such as hand hygiene and the use of personal protective equipment (PPE).For example hand hygiene audits for the hospital from April 2016 December and July 2015 where the score was consistently 98% and above.
- There was a member of staff in outpatients who was the infection control link nurse, who had additional training and responsibilities. For example undertaking investigations and root cause analysis relating to infections.
- During our inspection we learnt of a recent problem involving bacteria found in waste water of a machine used to wash endoscopes. We saw a thorough root cause analysis investigation was underway with advice from external agencies for example a microbiologist and the company responsible for the machine.
- Hand washing sinks were available with sanitising hand gel throughout all the areas we inspected. The two sinks within staff toilets did not have the health protection agency (HPA) 'hand washing technique' posters displayed although there were instructions printed on

the soap dispensers. All sinks in patient areas did have posters of 'hand washing technique' displayed. We witnessed staff used a good handwashing technique which was compliant with the HPA guidelines.

- During our inspection we observed staff adhering to the 'bare below the elbows' policy. PPE such as disposable gloves and aprons were readily available in all areas.
- Equipment was marked with a sticker when it had been cleaned and ready for use.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we saw staff using these.
- Decontamination and sterilisation of instruments was managed in a dedicated facility at the hospitals sister hospital. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics. Staff said there was a good working relationship with this facility.
- The clinical waste unit was secure and all 15 clinical waste bins we looked at were locked.
- The cleaning of the hospital was undertaken by hospital staff. Cleaning equipment was colour-coded and used appropriately; we saw evidence of cleaning rotas and checklists.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The sharp bins were clearly labelled and tagged to ensure appropriate disposal.
- However, in theatres the tall sharp bins were freestanding on the floor, these should be secure in a stand to minimise the risk of being knocked over and the contents spilt and ideally should be on wheels so it could have been moved when required.
- We noticed that sharp safe cannulas (a thin tube inserted into a vein) and sharp safe hypodermic needles (hollow needle) were being used. These devices reduce the risk of a member of staff receiving a sharps injury.
- We saw clinical and domestic waste bins were available and contained no inappropriate items. A member of staff was able to clearly describe to us the arrangements for the segregation of waste
- We reviewed 24 patient feedback cards many of which commented that the environment was very clean.

Environment and equipment

- We observed that there was a lack of storage facilities in theatres for large items and the recovery room was used as storage, this meant there was a risk to expensive equipment becoming damaged and an additional risk to staff injuring themselves on it. There were no risks relating to this documented on the risk register.
- Medical gases were securely stored in a brick building with a reinforced metal door with double locks. It was additionally fitted with entry and movement sensors. However, the hospital's also had an outside medical gas cylinder storage used for empty which was not secure and these cylinders were at risk of being stolen or falling on someone. The Department of Health (DOH) The Health Technical Memorandum (HTM) 02-01 Part A guideline states medical gas cylinders should be kept in a purpose built cylinder store that should allow the cylinders to be kept dry, clean condition and secure enough to prevent theft and misuse. We did not see an action plan to address this issue and it was not highlighted on a risk register. This meant the provider could not be assured that all cylinders were kept secured at all times.
- There were no piped medical gases to the ward, this meant the ward relied upon portable oxygen cylinders, and there was no action plan in place to address this issue and it was not listed on the providers risk register. The use of oxygen cylinders should be minimised and where necessary a business case for increased piped oxygen provision is developed in accordance with Department of Health (DOH) The Health Technical Memorandum (HTM) 02-01 Part A. We saw that there were an adequate number of portable oxygen cylinders on the ward which were in date and secured correctly to a wall.
- We inspected the medical gas plant room which was clean tidy and alarmed with a metal door. This prevented any potential sabotage to the supply of medical gases
- There were arrangements to ensure endoscopes were decontaminated and the risk of infection to patients minimised. We reviewed the cleaning records of the endoscopes which were all compliant with patient traceability, so it could be traced which endoscope was used on each patient.
- We saw there were records of six monthly service visits of the endoscope washers and quarterly water samples taken to be tested for the presence of bacteria.
- We reviewed a sample of endoscopes and all had passed the cleaning process and this was clearly documented.

Good

Surgery

- Staff told us there was good support from outside contractors should advice be required in relation to endoscopes for example infection control experts and we saw evidence of this.
- Staff told us that it had recently been highlighted that not all staff had been trained in a specific aspect of cleaning endoscopes and we saw the ward manager/ outpatient department manager had made arrangements for a company representative to deliver a training session at the following months team meeting.
- We reviewed the 'risk assessment and water hygiene survey report' from August 2014. We saw these detailed low, medium and high risks with an action plan; however the action plan was not commenced until January 2016. This meant the quality of water hygiene could not be assured and could have posed an infection control risk to patients.
- One member of staff told us that they felt the quality of the picture on the endoscopes was substandard and a capital bid had been put forward for replacement. However, this was not adversely affecting patient safety at the time of our inspection.
- There was a comprehensive equipment record which allowed for the monitoring of equipment in addition it provided evidence of the condition and age of equipment.
- We saw that portable appliance testing (PAT) labels were attached to electrical items showing that it had been inspected within the last year and was safe to use. We checked 43 electrical items and labels demonstrated 21 items had not undergone electrical safety testing in the last 12 months, 11 of these were all the same category of equipment (sequential compression device.) This meant the electrical safety and efficiency cannot be assured of these items.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate log books being kept and we saw evidence of these. We checked two anaesthetic machines and these had been serviced within the last 12 months .The inspection team identified the log books examined were all complete with signatures for the days theatres were in use.
- We saw theatres and anaesthetic rooms were generally well organised, clutter free and single use items such as syringes and needles were readily available. We noted there was a lack of signage in theatres for example indicating where emergency equipment was located. This is of particular importance with a high number of staff who worked infrequently in the department.
- In theatre, the difficult intubation trolley was not Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. Some anaesthetists worked within the theatres on an infrequent basis and would therefore not be familiar with non-standard equipment. However, there was a robust system in place to ensure daily checking of this equipment to ensure it was available for use in an emergency.
- We checked two resuscitation trollies; equipment stored on the resuscitation trolley was readily available and the trolley was located in a central position. We checked six pieces of equipment on each trolley and all were sterile and in date. We saw the resuscitation trolley checklists which demonstrated a robust checking process for the trolley within theatres. However, the ward trolley checklist showed on 15 occasions in the last month the daily check had not been documented. We raised this issue with the ward manager who showed us the checks had been recorded on the "Night Staff Checklist". The ward manager took immediate action to standardise the recording process. The staff we spoke with confirmed they had access to the equipment they required to meet peoples care needs.
- The use of Natural Rubber Latex (NRL) gloves have the potential to cause asthma and urticaria (itchy rash) including more serious allergic reactions, such as anaphylaxis (extreme serious allergic reaction.) The Health and Safety Executive recommends employers should carefully consider the risks when selecting gloves in the workplace, because of the importance of latex gloves as a source of exposure to NRL proteins. Employers must be able to demonstrate that they have carried out an assessment to select which type of gloves they should provide and have an effective glove use policy in place. We observed that latex gloves were being used within theatres, but not on the ward. However, we did not see evidence of risk assessments of the type of gloves provided for use in theatres or a glove use policy.
- We saw records of a deep cleaning and filter change schedule of the theatres. During our inspection we had concerns regarding a report dated a year ago which

related to the theatre air plant, however, we saw evidence that remedial repairs have been undertaken and the unit will be replaced by the end of the 2016/17 financial year.
- Theatres used a smoke extraction system for all major surgical cases, in accordance with Health and Safety Executive Evidence which prevents exposure and harmful effects of diathermy plumes (surgical smoke) to staff. (RR922) (2012) guidelines.
- In the theatre staff scrub area, we saw posters were displayed to remind staff of the National Patient Safety Alert (NSPSA) NHS/PSA/W/2015/005 'Risk of death or severe harm due to inadvertent injection of skin preparation solution.' This acted as a visual reminder when staff washed their hands of the importance of ensuring skin preparations used to sterilise skin was discarded after use to ensure it could not be inadvertently injected into the patient. We observed an operation being undertaken and saw that the staff member discarded the skin preparation after use.
- We saw Health and Safety Control of Substances Hazardous to Health (COSHH) assessments in theatres were up to date and displayed.
- We saw a bed transfer system was used within theatres to transfer patients this reduced manual handling and the potential for injury to staff.
- We saw there was a machine for testing blood on the ward and we saw records of a maintenance check on a monthly basis.
- We spoke to the maintenance manager who confirmed there was a new generator with sufficient oil and fuel to maintain electricity for a significant of time. Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut.
- The blood bank storage unit was locked with a digital coded lock, to ensure the safe storage of blood products.

Medicines

- The Ramsay Health Care UK Limited had a quarterly drugs and therapeutics meeting we saw evidence of these meetings which contained information regarding discussions of National Committee topics and findings.
- Staff told us drug stocks were checked weekly by pharmacy.
- We looked at controlled drugs (CD's) (medicines liable to be mis-used and requiring special management) in wards and theatres. We checked order records, and CD registers and found these to be in order. We saw ward staff checked stock balances of CD's daily.
- We found that medicine cupboards were orderly, neat, tidy and in alphabetical order.
- We saw that robust management controls were in place to access the drug rooms. The keys to drug cupboards were kept in a key safe with a digital lock. The nurse in charge held the keys to the CD cupboard and we observed signing in and out log of the keys.
- We saw that medicines were stored in dedicated medication fridges when applicable. We noted the temperature monitoring devices were integral to the drug fridges. We observed daily records correctly kept, staff were able to explain what the safe minimum and maximum temperature ranges were.
- We reviewed four prescription charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on the chart and on their identity band. The four charts we reviewed demonstrated that prescribing was in line with national guidance. This included compliance with the National Institute for Health and Care Excellence (NICE) VTE guidance, with a section in the front of the chart confirming a completed VTE assessment and that prophylaxis had been prescribed and administered.
- There was pharmacist support Monday – Friday 9am – 5pm. We saw that the prescription charts had been reviewed by a pharmacist who had documented input regarding medications.
- Pre-packed take home medicines were available on wards. Staff told us that the Resident Medical Officer (RMO) prescribed medications to be taken home and would dispense them from a central cupboard, attach a patient label and document the dose and frequency to be taken on the label. We saw records of medications dispensed. The medications were checked by a nurse to ensure they were correct and the nurse counselled the patient on the dosage and possible side effects of the medication with the patient prior to discharge. Staff were able to give us examples of frequently prescribed take home medications and common side effects which they warned patients of.

- We saw in theatres 'right patient right blood' safety notices were displayed, this provided a visual reminder to staff on the importance of pre administration checks to be undertaken prior to administering blood.

Records

- The Ramsay Health Care Limited had a Medical Records management policy dated January 2015 and we saw staff adhering to this policy. Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- We looked at five medical and nursing paper records. We saw a good standard of record keeping. Patients were given a paper copy of their discharge summary and a copy was manually sent to their GP.
- The surgical care pathways included pre-operative assessment such as previous medical history, social history, anaesthetic assessment, input from physiotherapy, discharge planning and allergies together with baseline observations.
- The care records included multidisciplinary input where required, for example, entries made by physiotherapy.
- Information security training was mandatory and 50% of theatre staff and 54% of ward staff were up to date with this training, this was worse than the Ramsay Health Care UK Limited target of 90%.

Safeguarding

- The Ramsay Health Care UK group had a Safeguarding adults at risk of abuse or neglect policy which was reviewed in January 2016.
- Staff demonstrated they were able to access the safeguarding policy quickly. A staff member was able to describe the process they would follow should they have any safeguarding concerns about a patient. The registered manager was the dedicated safeguarding lead and had up to date level three safeguarding training.
- There were safeguarding advisors in the hospital who acted as a resource for staff we saw the names and contact details displayed on posters throughout the departments.
- One hundred per cent of ward staff were compliant with level one and level two safeguarding training. One hundred per cent of theatre staff were complaint with level one safeguarding training and 98% were compliant with level two training. This was better than the Ramsay Health Care UK Limited target of 90%.
- Staff we spoke with confirmed they had received safeguarding vulnerable adults training as part of mandatory training.

Mandatory training

- Mandatory training was monitored and all staff expected to attend on an annual basis, the training was organised corporately by the Ramsay Health Care UK Limited. The Ramsay mandatory training programme included topics such as Health and Safety, Infection Control, Information Security, Manual Handling and Workplace Diversity. Training rates for individual topics ranged from 46 - 100%. There was an overall compliance rate of 66% for theatre staff and 67% for ward staff; this was worse than the Ramsay Health Care UK Limited target of 90%.
- Mandatory training data for consultants was not provided to us. The provider explained that low compliance with mandatory training was because the format and provider of the training had recently changed and they were in the process of changing over.
- We spoke with a doctor who was employed by an external agency; they described a robust process of ensuring their mandatory training was up to date.
- Staff told us mandatory training was a mixture of on-line training and face to face training, staff told us it was always completed in work time. Staff who were due to update during that period were now in the process of doing so, and these figures were expected rise over the next few weeks.
- Mandatory training was monitored and compliance discussed during appraisal, we reviewed three appraisals which included details of completed mandatory training.

Assessing and responding to patient risk

- The WHO (World Health Organisation) checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre.

Good

Surgery

- We observed specific WHO checklist's for different procedures for example for endoscopy and ophthalmology this ensured the most important safety factors relating to the procedure were highlighted and checked.
- We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes postoperatively. Staff told us compliance with the checklist was closely monitored and monthly audits of compliance took place on regular basis.
- The February 2016 surgical safety checklist audit demonstrated a compliance of 100%. We saw these audits. Staff told us if the check list had not been completed correctly it would be discussed with the individual staff member and any themes discussed at staff meetings.
- We observed multiple examples of the WHO checklist in use for example during a shoulder operation and endoscopy procedures. In all case they followed a standardised, accurate approach were well led and had good staff engagement.
- We observed that pre-operative team briefs and de-briefs were not documented; this meant any concerns that were highlighted were not recorded and could not be evidenced if issues occurred. This was not in line with the 'WHO Guidelines for Safe Surgery' 2009 and Royal College of Surgeons, 'The High Performing Surgical Team-Best Practice for Surgeons' 2014.
- The North Down's Hospital used a modified early warning System (MEWS) track and trigger flow chart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse) already undertaken when patients present to, or are being monitored in hospital. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support. We reviewed five completed MEWS charts which were completed correctly and we saw evidence of intervention when indicated.
- An audit of MEWS completion was undertaken in March 2016 this demonstrated 76% compliance against 17 set criteria and this was the first audit undertaken since the introduction of MEWS.
- Nursing staff told us medical support was readily available when required as the Resident Medical Officer (RMO) attended to patients quickly.
- A RMO told us that there was a robust support process in place should they require support or advice, and told us of several examples of when patients had suffered complications and how support and advice was available quickly initially via telephone and then the consultant would attend the hospital.
- We were given examples of unexpected complications in theatres for example a patient who had a severe anaphylaxis to a drug; staff described how this situation was dealt with effectively and safely.
- Local preoperative assessment policies should ensure pregnancy status was checked within the immediate preoperative period in accordance with NICE guidelines. The check should be recorded on preoperative documentation used by staff performing final clinical and identity checks before surgical intervention. We observed evidence of this guideline being used in practice.
- We saw all patients had a VTE assessment completed and all patients wore anti-embolic stockings. We saw completed of neurovascular assessments and all five patient records we reviewed had a pressure area assessment completed.
- There were three daily nursing handovers, one at the beginning of the day, one at lunchtime and the other towards the end of the day. In addition there was a morning 'huddle'. This was an informal meeting held at the start of each working day where the heads of department came together to discuss potential issues for the day. During our inspection we attended a morning 'huddle'; it was very efficient. There was a brief overview from the night staff and brief discussion of the plans and any potential issues for the day including staffing or changes to the operating lists.
- We saw 'avoid a fall nurse call bell' posters which encouraged patients to press the call bell and request assistance rather than risk having a fall. We saw all patients had their call bell within reach, and patients told us if they pressed it they were responded to almost immediately.
- We saw there were a variety of up to date clinical standard operating procedures in the management of emergency situations for example massive blood loss and the management of the deteriorating patient. These ensure a standardised evidence based approach to managing emergency situations, staff we spoke to confirmed that had access to these and were aware of the content.

- During our inspection a patient deteriorated and had to be transferred to another hospital, we saw a well-documented evidence of prompt intervention and rapid arrival of a consultant to provide support and assistance. We saw that the MEWS had been completed correctly and triggers prompted interventions, we saw evidence that the patient's family had been kept informed of events. The nurse caring for the patient told us that they would report the event on 'the hospital's electronic reporting system'.
- We undertook a review of the unplanned transfers and given the nature and volume of operations undertaken, all were appropriate and there were no common themes or concerns. There was a decreased rate of unplanned patient transfers to another hospital per 100 discharges 18 cases for the period January 2015 – December 2015.
- There were nine unplanned returns to the operating theatre for the period January 2015 – December 2015. We undertook a review of the unplanned returns to theatres there were no common themes and had all been treated appropriately.
- We observed handovers between theatre staff to recovery staff, which were good and communicated all the relevant information.
- We observed a theatre team brief; all staff introduced themselves and highlighted any issues regarding the surgery. Theatre staff received information at theatre 'briefs' and 'de-briefs' as well as at departmental meetings. Ward staff received information at safety briefings and handovers.
- The American Society of Anaesthesiologists (ASA) used a grading system of 1-6 which determines the fitness of patients. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma. Only patients that have been assessed at pre- assessment that are ASA grade one or two have operations undertaken at North Downs hospital. This was because there were no the facilities or staff to support patients who are more unwell. The decision was made by the nurse who undertook the pre assessment of the patient if they had any queries regarding patient's suitability it was discussed with an anaesthetist.

Nursing staffing

- There was occasional use of agency staff (less than 20%) between January 2015 - December 2015 for operating department practitioners (ODP's). No data was submitted for theatre nurses or care assistants. Agency use and 'man hours' were monitored through monthly head of department meetings.
- There was moderate level of vacancies as of 1st January 2016 (between 10% and 19%) for ODP's. There were no vacancies for health care assistants (HCA's) or nurses within theatres.
- There was a high level of vacancies (equal to or greater than 20%) for nurses working in inpatient departments (including surgery ward). The ward manager told us two members of staff had recently been recruited and they were still actively recruiting.
- There was a low level of vacancies (less than 10%) for administrative and clerical workers (hospital-wide).
- Theatres used the Association for Perioperative Practice (AfPP) staffing guidelines to ensure there was an adequate number of appropriately trained staff available for each theatre. Theatres did not display staffing guidelines but inspection staff saw evidence from staffing rotas and allocations that the guidelines were adhered to.
- We saw the staffing arrangements were two qualified nurses and one HCA on the early shift, the same for the afternoon shift and two qualified nurses on the night shift.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients surgical services were compliant with this. We saw two staff rotas that demonstrated planned staffing met actual staff ratios for each.
- The ward did not have planned versus actual staffing displayed. Staff told us that understaffing would be reported on the hospital's electronic incident reporting system.
- The staff and patients we spoke to said there were enough nurses to provide safe compassionate care.

Surgical staffing

- There were 128 consultants who had practising privileges at the hospital, all of whom had been undertaking work at the hospital for over 12 months. Practising privileges is a term which means consultants have been granted the right to practise in an independent hospital.
- The Resident Medical Officer provided continuous medical cover and conducted regular ward rounds to

ensure that all patients were appropriately treated and safe. Any changes in a patient's condition were reported to the consultant and their advice was followed in respect of further treatment.

- The hospital had two RMO's who were employed by an external agency and provided immediate medical support 24 hours a day seven days a week. They slept on site and worked a shift pattern of working two weeks on and two weeks off.
- Staff told us that a formal hand over process was undertaken between RMO's however we did not see this as there was no change over during our visit.
- We spoke to a RMO who confirmed support from consultants was always available and gave examples of when advice had been given via the telephone prior to attending the hospital. A RMO told us that consultant lead care was available out of hours and at weekends.
- We saw there was a rota of the consultant surgeon who was on call, we asked staff to demonstrate how they would identify who the consultant was. Staff showed us a folder which was easily accessible which contained a copy of the rota they were able to identify the relevant consultant surgeon and anaesthetist. Consultants informed the hospital management team when on annual leave.
- We observed, and staff confirmed that the surgeon was available for 30 minutes immediately after a procedure or operation before leaving the hospital in case any complications occurred. After leaving the hospital they were available by telephone 24 hours a day as they maintained responsibility of the patient for the duration of the patients stay. We were informed that the anaesthetist was available via telephone for advice for 24 hours following a patient's procedure. Staff reported that did not encounter difficulties contact the relevant anaesthetist during this post-operative period.

Major incident awareness and training

- Regular emergency scenario training was undertaken the last exercises were the 11th and 13th May 2016.We saw documentary evidence of these training exercises and feedback from them.
- Staff told us that they enjoyed taking part in the scenario training and found it extremely useful as it was rare they experienced such emergencies and it kept their skills up to date.
- A recent fire evacuation exercise had taken place to practice evacuating the hospital of staff and patients in the event of a fire. However we found that only 45% of theatre staff and 54% of ward staff were up to date with Emergency Management and Fire Safety training which was mandatory at the hospital. This was worse than the Ramsay Health Care UK Limited target of 90%.

Are surgery services effective?

Good

We rated effective as good because:

- Patients have good outcomes because they received effective care and treatment that met their needs and which was in line with best practice.
- Patient surgical outcomes were monitored and reviewed through formal national and local audits to ensure care was evidence based and adhered to best practice guidance. Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes.
- Patients had comprehensive assessments of their needs.
- There were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists.
- Staff were qualified and had the skills needed to carry out their roles effectively and in line with best practice and were supported to deliver effective care and treatment, through supervision and appraisal.
- Staff had regard to the Mental Capacity Act (MCA) Code of practice.

However:

- The competence and capability of the surgical assistants could not be assured.

Evidence-based care and treatment

- Staff were able to access national and local guidelines through the intranet, and information folders which were readily available to all staff.
- There was a range of clinical pathways and protocols for the management and care of various surgical procedures which had been developed in conjunction with healthcare professionals from a range of specialties, for example the knee and hip replacement pathway. We reviewed two pathways which were fully completed and easy to understand.

- Nursing staff confirmed clinical governance information and changes to policies and procedures and guidance had been cascaded down by the ward manager via emails, communication diaries, team meetings, safety briefings and team briefings.
- Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations for example early recovery after surgery (ERAS) in knee and hip replacement surgery. The enhanced recovery programme aims to improve patient outcomes and speed a patient's recovery after surgery.
- Following surgery patients were nursed in accordance with the National Institute for Health and Care Excellence (NICE). NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. Sometimes, the health of a patient in hospital may get worse suddenly (becoming acutely ill.) There were certain times when this is more likely, for example after surgery. Adherence to this guidance by monitoring patients (checking them and their health) regularly after surgery and taking action if they show signs of becoming worse can help avoid serious problems.
- Within the theatre, we observed that staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection. For example we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine.
- The Ramsay Clinical Governance Committee reviewed Key Performance Indicators (KPI's) across the group and hospitals are informed if they are outliers, in order that they can review this.
- The surgical unit has Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation. JAG is a quality improvement and service accreditation programme for gastrointestinal endoscopy. They support and assess endoscopy units to meet and maintain the JAG standards. The endoscopy services at North Downs hospital has JAG accreditation, which is due for renewal in 2019.
- Staff understood specific NICE guidelines that related to operations undertaken and additional NICE guidelines for example in relation to VTE management. Staff said that NICE guidelines were referred to in discussions with staff about patients' care and treatment.
- NICE guideline updates were a standard agenda item on the clinical governance committee meetings to ensure new guidelines were discussed and arrangements for implementation made.
- Staff told us they were able to assess relevant NICE guidelines on the intranet.

Pain relief

- All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief.
- Patients told us nurses responded quickly when extra pain relief was required and the effect checked by nurses.
- We saw patients were given a 'managing your pain after your operation leaflet' prior to their operation .This contained information regarding frequent painkillers administered, possible side effects and information regarding painkillers taken home.
- We saw the use of a pain assessment tool and analgesia ladder, which asked patients to rate their pain between 1 and 10, 1 meaning no pain and 10 being extreme pain. The analgesia ladder set out guidelines and an algorithm regarding the management of pain.
- Consultant anaesthetists with an interest in pain relief gave advice on pain management however, there was no dedicated pain team.

Nutrition and hydration

- There was a robust process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in line with best practice.
- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of being under nourished.
- The five records we reviewed had a nutrition and hydration assessment undertaken.

- We reviewed patient menus. There were different menus for NHS and private patients. These included options for people with specialist dietary needs such as religious beliefs or vegetarians.
- Patients with specialist dietary requirements were highlighted at pre- assessment and the catering staff informed.
- We saw reference folders which contained specialist diet instructions such as high fibre diets, low potassium and gluten free which the catering staff used to ensure compliance.
- There was no dietitian on-site although the hospital had arrangements for a dietitian to visit if patients required this. We saw that the hospital's chef had undertaken additional training in nutritional and dietary requirements.
- Patients we spoke to said they were offered enough to eat and drink and were happy with the variety and standard of food offered.
- All the patients we observed had water jugs on their bedside table so cold access drinks.

Patient outcomes

- National clinical audits were completed, such as Patient Reported Outcome Measures (PROMs) in relation to hip replacements. The hospital took part in PROMs, Hernia, National Joint Register (NJR) and Hip/Knee surveillance audits.
- The PROMs audit is used for the routine collection and use of patient reported outcome data. Data is collected for patients both before and after surgery to assess a variety of patient factors pre and post-surgery. All PROM's scores for groin hernia, hip and knee replacement primary were within the expected range of England average, with all patients reporting an improvement in their condition after surgery.
- North Downs Hospital had good outcomes and consent processes in relation to hip and knee replacement procedures. Outcomes were measured nationally for example via the National Joint Registry.
- Comparative outcomes of consultants were measured locally via local audit, and the Ramsay Health Care Limited via information sharing.

Competent staff

- The hospital had in place appropriate job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post.
- We reviewed five new members of staff's employment checks which were completed in line with the hospital's recruitment policy.
- Staff member's registration status was monitored by a local electronic database and managers received emails prior to a staff member's registration expiry.
- In addition we saw a central electronic database which contained registration expiry dates of staff and the computer system did not allow staff to be rostered to work if their professional registration had expired. Staff also received an email when the registration was due for renewal.
- New employees undertook both corporate and local induction with additional support and training when a need was identified. We saw evidence of a new starter's induction programme which was comprehensive; the staff member was happy with the induction process. We also saw an example of a competency document that new staff had to complete before they were permitted to work independently and out of hours. This ensured staff had been assessed as competent to undertake their role.
- The agencies used to provide staff had been audited to check their compliance against NHS employment standards. This provided assurance that agencies ensured their staff met these standards.
- We reviewed the pre-employment checks of one RMO who was contracted to work at North Downs hospital via an external agency these were complete and had been reviewed and authorised by the head of the Medical Advisory Committee (MAC.) Both RMO's had up to date advanced life support training.
- We saw all consultants who worked at North Downs hospital had to have the correct pre-employment checks completed in order to be granted practising privileges. The head of the MAC committee reviewed and authorised all practicing privileges applications. We reviewed seven consultants records and all checks were complete and in date. We saw evidence of correspondence to consultants when a condition of practise privileges had expired for example police check, it warned practise privileges would be suspended if not acted upon promptly. The head of the MAC committee was informed of any such issues.

- The hospital tried to use the same agency staff who were familiar with the environment. We saw orientation and induction packs for agency staff which included training in the use of specialist equipment and were adequate.
- During the period January 2015 – December 2015 more than 75% of all surgical staff had an appraisal undertaken and 100% of theatre staff had an appraisal undertaken, , this was worse than the Ramsay Health Care Limited target of 90%.
- Learning and development needs were identified during appraisal. Staff were supported in their learning and development by their manager and the training lead.
- In theatres, we saw staff member's individual equipment training records; this demonstrated they had received appropriate training to use equipment safely.
- Staff told us the hospital was a good learning environment with access to mandatory training and further development.
- All staff who worked in surgery were expected to undertake Immediate Life Support (ILS) training including HCA's, 90% of theatre staff were complaint with up to date ILS training and 69% of ward staff were compliant. Basic Life Support (BLS) training had been undertaken by 73% of theatre staff (non-clinical) and 54% of ward staff (non-clinical), this was worse than the Ramsay Health Care Limited target of 90%.
- Up to date Advanced Life Support (ALS) training had been undertaken by 20% of consultants, 25% of consultants had up to date ILS training and 27% of consultants had up to date Basic Life Support (BLS) training. We saw this was recorded on consultant files including when this training had been carried out elsewhere. However, no data was provided which related to the status of training for 12 consultants.
- We saw a comprehensive computer database of all doctors who had practicing privileges to work at the hospital
- We examined four records of staff who worked at the hospital as first assistants (their role is to assist the surgeon during surgery). They were not employed by the Ramsay Health Care Limited and were provided by an external agency. The hospital did not keep details of relevant qualifications and medical indemnity insurance for these staff on record. This meant the competency and knowledge of these staff members could not be assured.

Multidisciplinary working

- Care planning took place at pre-assessment with input from the multidisciplinary team, there was involvement from members of the team including doctors, nurses and allied healthcare professionals.
- Overall, staff reported good multidisciplinary working with other services within the hospital and with external organisations, such as local authorities and general practitioners.
- Staff in theatres and the ward manager undertook planning meetings to discuss future theatre lists which ensured availability of staff and equipment. The units worked closely with the pre-assessment, to co-ordinate and prioritise the admission of patients.
- We observed a good culture in multidisciplinary working and a good team ethos. In particular we witnessed good interaction between patients and physiotherapists who used a variety of equipment and techniques to enable patients to mobilise after surgery.
- We observed a handover between a physiotherapist and nurse which include the current status of the patient, a progress plan and discharge plans.
- There was a robust process in place to ensure district nursing support in the community after the patient had been discharged. This was detailed in an information folder which was easy for staff to access.

Seven-day services

- The hospital was open routinely Monday to Friday. Operations frequently took place on Saturday but there was no senior nurse or pharmacy support on-site at this time. However. there was a senior nurse on call for the hospital and advice and assistance could be provided from the hospital's sister hospital.
- If there were no patients and the hospital was closed, arrangements were made with their sister hospital in Ashtead who took any enquiries from patients and if necessary saw them.
- Consultants provided details of cover arrangements for when they were not available when obtaining practising privileges.
- Radiology and physiotherapy services were available at weekends by prior arrangement.

Access to information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as

blood results and imaging to support them to care safely for their patients. During the inspection we requested three patients' records that had previously undergone operations; they were supplied to us quickly within 10 minutes on each occasion, as they were kept on site.
- There was an electronic system for recording the results of patient investigations. Clinicians could view the results from various locations.
- There was a mixture of computer systems and paper records for accessing and recording information. For example there was a computer system in theatres which gave information regarding the status of the patient which ward staff could also access, which helped to keep relatives informed. Staff did not report any issues relating to using different systems.
- Staff we spoke to told us they felt there was excellent communication between medical and nursing staff.
- Staff told us most clinical information and guidance was available on the intranet and information folders. In addition, a communication diary was used which staff read at the beginning of each shift.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Staff were aware of their responsibilities under the mental capacity act (MCA) 2005 and deprivation of liberty safeguards (DoLS) and were able to describe the arrangements that were in place should the legislation need to be applied.
- We were told that best interest decisions and deprivation of liberty decisions were taken where indicated and these were formally documented.
- We reviewed a patient's notes which contained a DoLS and it was compliant with the MCA code of practice. Staff had a completed mental capacity best interest's assessment.
- Training on DoLs and the Mental Capacity Act 2005 was part of mandatory training and staff reported it was easily accessible
- Staff were able to describe the legislative requirements regarding consent and confirmed that policies and procedures were available to ensure that informed consent was obtained from the appropriate individual.
- Patients we spoke to told us they had been given clear information about the benefits and risks of their surgery in a way they could understand prior to signing the consent form.
- Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.
- We reviewed five consent forms they all identified all possible risks and complications following the procedure. The consent forms were fully completed and contained no abbreviations so that patients could easily understand what had been written.

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Are surgery services caring?

Good

We rated caring as good because:

- The patients we spoke with during the inspection told us they were treated with dignity and respect at all times and had their care needs met by caring and compassionate staff. We observed patients being treated in a professional and considerate manner by staff.
- Patients felt involved in their care and participated in the decisions regarding their treatment, and staff were aware of the need for emotional support to help them cope with their treatment.

However:

- The hospital achieved a below average response rate for the friends and family test.

Compassionate care

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience.
- In April 2016, 99% of NHS patients who were referred to North Downs hospital for day case treatment said they would recommend or highly recommend the service. One hundred per cent of NHS inpatients said they would

recommend or highly recommend the service and 98% of private patients would recommend or highly recommend the service. It should be noted that the response rates for both private and NHS in-patients was low as six and 19 respectively.

- We saw FFT information displayed throughout the clinical areas and in the staff rest room.
- North Downs hospital received 11 items of rated feedback on the NHS Choices website between January 2015 - December 2015:
  - 10 patients were extremely likely to recommend the hospital
  - One patient was neither likely nor unlikely to recommend the hospital
- The patients we spoke to were all very positive about the care they had received and said nurses had time to give compassionate care. Patients said they were treated with compassion, dignity and respect.
- Throughout our inspection, we witnessed excellent staff interaction with patients. We observed how the nurses assisted patients, with compassion and skilled care. We observed staff went out of their way to care for patients.
- However, the North Downs hospital achieved 70% site score in the patient-led assessments of the care environment (PLACE) 2016, for treating patients with privacy, dignity and wellbeing, which is worse than the national average of 86%.
- In theatres we observed staff delivering care with empathy and compassion. We saw theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious. We saw theatre staff gave consideration to ensuring patients were not left exposed unnecessarily and that patient's dignity was preserved when opening theatre doors.
- We reviewed 24 patient feedback comment cards all of which contained positive comments ,the comments included; 'five star service' ,'very friendly staff', 'if only all hospitals could be like this', 'excellent staff and care', 'traditional values and standards' and 'service good and informative by professional staff'.
- Patients' who were self-pay were given adequate information regarding the cost of their operation prior to admission in a sensitive manner.
- We observed staff showed determination and creativity to overcome obstacles in delivering care for example staff tried to ensure the room they were allocated was the most suitable environment for the patient's needs.

Understanding and involvement of patients and those close to them

- We spoke with patients at different stages of their surgical journey, they told us they felt involved in their care and in decision making about their treatment.
- We spoke to some patients' relatives who said they has been involved in their relatives care and had been given regular updates.
- The patients we spoke with told us they were given adequate information about the specific surgical procedure that applied to them.
- Patients were able to tell us the name of the nurse looking after them and we witnessed all staff introduced themselves to patients they had not met before.
- We observed a member of staff explaining how to ensure the correct fitting of anti-embolism stockings and checking the patient had support at home to help them with them.
- Patients in day surgery said they were kept informed of their approximate surgery time which helped to manage their stress and anxiety.

Emotional support

- Surgical services had arrangements in place to provide emotional support to patients and their families when needed.
- Patients told us that staff had enough time to provide them with adequate emotional support.
- Pre-admission staff told us that where it was identified that patients required extra support this was arranged where possible before admission and discussed with the multidisciplinary team. For example patients with complex needs such as learning difficulties were scheduled first on the operating list to minimise waiting time and anxiety time.
- We were given examples of relatives attending the anaesthetic room with their relative to provide emotional support.
- We saw there was availability of specialist nurses via external agencies for example stoma nurses.
- We saw a patient undergoing a procedure under local anaesthetic in theatre who was extremely nervous and upset. We observed staff giving her sips of water, trying to comfort her and sat with them throughout the procedure, the patient was visibly less anxious after the staff member's intervention.

Good

Surgery

Are surgery services responsive?

Good

We rated responsive as good because:

- The needs of local people, commissioners and stakeholders were taken into consideration when planning services and patients' could access the right care at the right time.
- There were established surgical pathways of care through the hospital from admission to discharge. Care and treatment was coordinated with other services and other providers.
- Complaints were acknowledged, investigated and responded to in a timely fashion. There was openness and transparency in how complaints were dealt with. Improvements were made to the quality of care as a result of complaints and concerns.
- Facilities and premises were appropriate for the services being delivered.

Service planning and delivery to meet the needs of local people

- The hospital was in the process of trying to expand some of the services offered after research of the local population, for example enhancing and increasing cosmetic surgery services.
- Staff told us that there was a flexible approach to working during busy times and staff 'pulled together' and worked as a team. If possible staff would finish their shift late at busy times and take time back at less busy times. This meant the needs of the service were met.
- The NHS patients we spoke to all said they had requested to come to North Downs hospital via 'choose and book' at their GP's.

Access and flow

- When patients arrived at the hospital for an operation or procedure they reported to reception and were directed either to the day surgery ward or the inpatient ward. The patients are prepared for their operation or procedure in either location and wait to be escorted to theatre for their operation or procedure, after their operation or procedure they are transferred to the recovery room to recover and ensure they are stable and pain free. Then they were collected and taken to either the day surgery unit and discharged home or returned to a room on the ward for overnight stay.
- The theatre manager reviewed the operating lists in advance; this ensured there was adequate time, staff and equipment available.
- There was adequate discharge arrangements in place with patients provided with contact details of who should be contacted should any problems occur.
- We saw accurate records were kept when patients had been transferred to an external organisation, such as a NHS hospital.
- Patients told us they were aware of what the approximate time of their operation would be and were kept informed of delays.
- Daily bed occupancy records were completed by surgical managers in advance which identified potential problems, reviewed demand, capacity and workforce. This meant delays any potential problems could be predicted and resolved in advance minimising delays and disruption.
- We observed that certain rooms on the ward were not suitable for all patients due to the design of them for example patients with mobility issues. The ward manager explained how the notes of patients and their procedures were assessed in advance to ensure the most suitable room was allocated.
- The North Downs hospital had consistently met the 90% national target for patients Referral to Treatment (RTT) waiting times between January - November 2015 only achieving worse than the target in December 2015.

Meeting people's individual needs

- We heard the hospital was generally able to meet patients' individual needs for example there were positive initiatives in place to support patients living with dementia and patients with memory problems. For example a blue pillowcase was used to identify patients with memory problems. This was a visual aid to staff to remind them that these patients may require more help and assistance.
- The hospital did not have any level two or three critical care beds. To mitigate this risk, the hospital only operated on patients pre-assessed as grade one or two

under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.
- In the patient-led assessments of the care environment (PLACE) audit 2016 North Downs hospital scored 78% which was better than the national average of 75% in relation to care for patients living with dementia.
- We saw the hospital had a library service which enabled patients to borrow books during their stay.
- Staff told us prior planning took place for patients admitted with special needs, pre- assessment would notify ward managers of the patient's specific needs so adjustments could be made. We saw in the kitchen notifications had been sent to the chef to advise them of specialist diets of patients; this meant the chef could plan a suitable menu in advance.
- Staff told us that translation services were available in a variety of forms, for example face to face or telephone translation, however it was rarely required.
- There was access to patient information literature however we noticed it was only available in English. We saw that specific information leaflets were available which were given to patients at pre-assessment therefore they had time to read the information prior to their operation. This also meant that relatives had the opportunity to read the information and were well informed.
- All food at North Downs hospital was cooked on site; we observed the kitchen area which was clean and well organised. We spoke to the catering staff who took pride in their work and created healthy tasty food for patients and staff.
- In the PLACE audit 2016 North Downs hospital scored 91% for standard of food which was better than the national average of 88% and 94% for the standard of organisational food which was better than the national average of 88%. However they scored 84% for standard of ward food which was worse than the national average of 89%.
- The patients and staff we spoke to said the food was of good quality with a variety to choose from and catered for individual needs, for example, kosher food and vegetarian options.
- We saw there were good facilities for patients with a disability or those in a wheelchair for example electric doors. Not all the rooms on the ward were suitable for disabled patients however the staff went to every effort to ensure the most suitable room was used.
- All patients we spoke with gave us positive feedback about the service, citing examples such as cleanliness; friendliness of staff, discharge planning and quality of the food

Learning from complaints and concerns

- The hospital had clear processes in place for dealing with complaints. Patients we spoke with understood how to complain. Staff were aware of the complaints process and were able to discuss changes of practice with us that had occurred following complaints investigations.
- The hospital followed their corporate complaints policy for managing complaints. The policy was due for review in April 2016 and at the time of our inspection the policy was under review.
- There was a procedure within the policy that set out necessary steps to be taken upon receipt of an informal or formal complaint. We saw evidence of learning from complaints and staff were able to describe learning, an example given was the introduction of the blue pillow case to identify dementia patients, after a compliant and incident review.
- When a complaint was logged, a member of the senior management team determined who would deal with it. The investigation was logged on the hospital's electronic report system and also in a hard copy file. The general manager or a delegated senior team member verified the responses and agreed sign off. Meetings with patients and relatives were arranged if they felt it would be helpful to do so.
- In the Ramsay Hospitals UK Limited the general manager had overall responsibility for the management of complaints although other senior staff may be involved in the investigation and resolution.
- The complaints process was outlined in information leaflets, which were available on the ward area.
- Complaints were a standard agenda item on the clinical governance committee meetings and heads of department meetings, we saw the minutes of these meeting to confirm this.

Good

Surgery

- There were mechanisms in place for shared learning from complaints through the staff meetings, team briefings and safety briefings.
- Staff told us there was a patient focus group which reviewed feedback such as complaints and any themes or lessons learned.
- There were 20 complaints received in surgery during the period of 12th January 2016 – 25th March 2016. We undertook a review of the complaints received the top complaint which made up 20% of the complaints related to breakdown in communication between patients and staff.
- We were given examples of changes to practice from learning from complaints, for example patients had complained they did not know who to contact after their discharge should problems occur. We saw a sticker was placed on the front of the patients take home information pack which contained contact information.
- Hospital managers told us that complaints were acknowledged within two working days and then a response provided within 20 working days. If this timescale was not possible, for example because further information was required, a holding letter was sent to the complainant so that they were aware their complaint had not been forgotten and was still being looked into.

Are surgery services well-led?

Good

We rated well-led as good because:

- There was clear statement of vision and values 'The Ramsay Way' driven by quality and there was a focus on risk management.
- Managers spoke enthusiastically about their ward or department and were proud of the teams they had working with them. Leaders were dynamic, supportive and visible in clinical areas and they inspired others to work together
- The leadership, governance and culture promoted the delivery of high quality person-centred care. Information on patient experience was reported, reviewed and acted upon and hospital encouraged local initiatives to improve patient experience, care and treatment.
- Staff were passionate about teamwork and created a friendly welcoming environment.

However:

- There was not a surgery specific clinical risk register.
- How actions identified in post incident plans would be actioned, audited and who was responsible for their implementation was not explicit.

Vision and strategy for this this core service

- The service had a variety of developments to further enhance the surgical services for example expanding cosmetic and eye surgery service. We spoke to a specialist nurse on the plans and scope of the project to develop this.
- Staff told us they were aware of and supported the 'Ramsay Way' vision and values, and they could tell us what the strategies, meant to them, which was to provide the best care for patients and to put patients first.
- We observed the 'Ramsay Way' vision and values were prominently displayed. We heard staff say that they are inspired to work 'The Ramsay Way'

Governance, risk management and quality measurement for this core service

- The hospital held meetings through which governance issues were addressed. The meetings included the Medical Advisory Committee (MAC) meeting, Heads of Department (HOD) meeting, Senior Management Team (SMT) meetings and the Clinical Governance Committee.
- The MAC was due to meet quarterly but there were only three meetings in 2015 as one meeting was not quorate. The minutes from the last two MAC meetings supplied by the hospital for June and October 2015 demonstrated that key governance areas were discussed including training, risk assessments, clinical incidents, never events and complaints.
- Although there was a governance framework in place some responsibilities were not clearly defined and the process that monitored the outcome of audits, complaints, incidents and lessons learnt needed further improvement.
- We saw thorough root cause analysis (RCA) of incidents with learning. However, how the actions would be implemented, audited and who was responsible for their implementation was not explicit.

- We saw that quality measurements of procedures and operations were monitored and reported to the relevant agencies. However, due to the sample size it was not possible to accurately benchmark these. For example, the amount of cases submitted to the national joint registry (NJR) is not comparable to a large NHS hospital. We saw any operative complications were discussed at the clinical governance meetings.
- Staff told us they could raise issues for discussion and resolution through a network of performance, clinical governance and safety meetings which took place on a planned basis throughout the surgical services, these included head of department meetings, senior management team meetings and clinical governance meetings.
- We reviewed the risk register however, this was a corporate Ramsay Health Care UK Limited register and did not contain any specific surgical clinical risks for this hospital. It outlined corporate expectations of staff to work in a manner that reduced risk and encouraged escalation of risks through the management structure.
- We spoke to managers concerning risk management processes and were told that all incidents, risks and complaints are logged and managed on the hospital' electronic reporting system. This meant there was system of governance to monitor, identify and mitigate risk. However, although the hospital had showed us evidence of risk assessments and risks logs for each department, risks from clinical departments and specialities were not entered on the risk register. This meant that there was no clear approach to managing and monitoring clinical risks.
- There was a variety of service level agreements in place to support hospital services for example the testing of blood, availability of blood products and the analysis of specimens. We saw evidence of these and staff reported good working relationships.

Leadership

- We saw clinical leaders and managers encouraging supportive, co-operative relationships among staff and teams, and compassion towards patients. Staff were highly complementary about the management team. Staff told us members of the senior management team were visible and approachable.
- There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas. Senior nurses undertook relevant leadership and management training.
- Staff reported the leadership culture made them feel valued, included and respected. All staff spoke with passion and pride about working at the North Downs hospital and all spoke enthusiastically about what the future held for the hospital.
- We saw and heard good examples of nursing leaders and managers nurturing others. For example we spoke to a member of staff who had started work at North Downs hospital as a newly qualified nurse, they explained how they had been supported, supervised and had learning needs identified.
- We heard regular staff meetings were held in all the departments these had a sent agenda and we saw evidence of meeting minutes.

Culture within the service

- The staff that we spoke to were extremely proud to work for the organisation and felt that the care they provided was excellent. None of the staff we spoke with said they had experienced bullying from their colleagues or managers.
- Staff told us they felt able to raise concerns and felt that the hospital was transparent with a "non-judgemental, no blame" culture. We heard there was a strong culture of openness from junior to senior staff, clinical and non-clinical
- Staff told us the culture of the service was focused on meeting the needs of patients. Staff told us it felt like a 'family' working at the hospital and it is a supportive place to work.
- Human Resources data supported the views of staff. There was a low rate of sickness (less than 10%) in the reporting period January 2015 – December 2015. Data given to us by the hospital was for all staff groups combined including inpatient, outpatient and theatres.
- There were high levels of staff stability (equal to or greater than 80%) for health care assistants (HCA's) working in theatre departments, nurses working in theatre departments and operating department practitioners (ODP's.)
- Staff had a 'can do' attitude and went to great lengths to ensure services met the needs of patients without delays or cancellations.

Good

Surgery

Public and staff engagement

- The hospital used various means of engaging with patients and their families. These included surveys, such as the 'Friends and Family Test', inpatient NHS surveys and Ramsay Care UK Limited group surveys.
- Patients and the public were given a wide range of information from the hospital's website for example information regarding NHS choices, self-funding options and performance outcomes.
- The FFT results were displayed, along with any actions from patient feedback.
- We saw that there was a service award recognition scheme and several members of staff had achieved certificates of recognition.
- There were notice boards in the staff rest room which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents. The departments we inspected had regular monthly meetings which had a set agenda and action points and staff were able to give us examples of topics discussed.
- We saw that there was an employee action group and meeting minutes were displayed in the staff rest room. Staff said they felt valued and there was flexible working and the managers were 'family' and 'child' friendly. We were given examples of the hospital investing in their staff to improve their health and wellbeing for example an employee health surveillance service for staff.

Innovation, improvement and sustainability

- We saw staff wanted to learn, develop and improve their skills; they were given protected time, resources and encouragement to do so.
- Staff told us that innovation and improvement was recognised, shared and celebrated, via the staff forum committee.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient and diagnostic imaging services at the North Downs Hospital covers a wide range of specialties including dermatology, ear nose and throat (ENT), endocrinology, ophthalmology, orthopaedics, gastroenterology, general surgery, general medicine, gynaecology, neurology, ophthalmology, pain management, plastics, podiatry, physiotherapy, psychiatry, rheumatology and urology.

The diagnostic and imaging department carries out x-rays and ultrasound scans. More complex tests such as magnetic resonance imaging (MRI) and computerised tomography (CT) scans are provided by North Downs sister hospital at Ashstead.

North Downs hospital provides outpatient services for adults over the age of 18. Appointments are offered from 8 am to 8 pm Monday to Friday with some additional clinics on Saturday mornings. Diagnostic imaging services are offered to adult private patients over the age of 18 and adult NHS patients over the age of 19. Appointments are offered from 8 am – 8 pm Monday to Friday.

The outpatients department (OPD) is situated on the first floor and consists of four consultation rooms and a dedicated treatment and minor operations room. The imaging and diagnostics department is based on the ground floor and consists of one ultrasound room and one x-ray room. The physiotherapy department is situated on the second floor of the building.

The physiotherapy service was outsourced and therefore we did not inspect the delivery of this service. The administrative assistants working in this department however are employed by North Downs hospital and so have been included in this report.

NHS patients are referred by their General Practitioner (GP). NHS services are commissioned by local clinical commissioning groups (CCGs). Self-funding or insured patients can access the services via direct referrals.

Eighty-three per cent of the hospital activity is generated in the outpatient department. There were 19,342 outpatient attendances between January and December 2015. Of these, 10,979 (57%) were NHS funded and 8,363 (43%) were privately funded.

As part of our inspection we spoke with four patients and 18 members of staff including consultants across the different specialities of nurses, healthcare assistants, radiographers, administrative staff and managers. We observed care and looked at seven sets of patient medical records; five sets in the outpatients and two sets in radiology.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the North Downs Outpatient and Diagnostic Imaging service as good overall because:

- Systems were in place for keeping patients safe. Staff were aware how to report incidents and safeguarding adult issues. Staffing levels were sufficient to meet the needs of patients.
- We observed effective multi-disciplinary working and staff sought consent from patients in accordance with policy.
- Staff were enthusiastic and caring. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received regardless of how they were referred or funded.
- Interpreters could be booked for patients whose first language was not English, if required. Wheelchair access was available throughout the hospital.
- There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Managers provided visible leadership and motivation to their teams. There was appropriate management of quality and governance at a local level.

However, we also found:

- The clinical environment did not promote patient safety and there were issues around equipment intended for one use being used repeatedly.
- There was insufficient assurance in relation to the maintenance or calibration of equipment and insufficient controls in place to prevent mis management of prescription forms.

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- The clinical environment did not meet government specifications for the design of healthcare premises.
- There were inadequate controls to prevent misuse of prescription sheets.
- There were a number of single use apparatus that were being re-used in the treatment room.
- There was insufficient assurance in relation to the maintenance or calibration of equipment.
- The World Health Organisation (WHO) checklist for dermatology procedures was not fit for purpose.

However:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses, and learning from incidents was discussed and shared across the department.

Incidents

- Over the last 12 months there had been no reported never events for the outpatient or diagnostic imaging department. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death.
- All staff we spoke with knew how to report incidents through the hospital's electronic incident reporting system. They were aware of the type of incidents they needed to escalate and report and some staff were able to give examples of recently reported incidents.
- All incidents were discussed at monthly Clinical Governance Group meetings and we saw three sets of minutes from these. The Heads of Department (HoD) meetings also discussed 'significant events/complaints' and we saw three sets of minutes from these meetings.
- There were very few incidents reported for the diagnostic imaging department and therefore difficult to analyse for any themes. There were three incidents reported in the radiology department in 2016. There were four recorded in 2015.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- We saw that the hospital had a duty of candour policy and that staff were aware of the terminology, the process they described in communicating with patients and their relatives reflected openness and transparency.
- The radiology manager was able to describe an incident that occurred where there was missed pathology by the radiologist. Following this incident the radiologist and senior hospital staff met with the patient and their family. We saw evidence of a detailed investigation of this incident and the adherence of the duty of candour process.

Cleanliness, infection control and hygiene

- A staff member told us that naso-endoscopes (an instrument used to view the larynx) were stored in the sluice (dirty utility room) and then transferred into the clean utility room which could not guarantee sterility of the equipment. We checked this with the Infection Prevention and Control (IPCT) link nurse confirmed that scopes were decontaminated in the sluice area with an appropriate cleaning and decontaminating agent before being transferred into trays and packaging in the clean utility room. This was acceptable practice that had changed in the last two weeks.
- The housekeeping staff were responsible for cleaning rooms up to the level of the couch, and the nursing staff responsible for anything above couch height. We saw cleaning schedules for both nursing and housekeeping staff that were signed and dated daily.
- On each consulting and treatment room door, there was a green 'I am clean' sticker. These stickers were intended to be used on equipment after they have been individually cleaned or decontaminated. Staff told us that these were also used by the cleaners to indicate that the room has been cleaned at the end of each day and were visible on each of the consulting and treatment room doors. However, in the treatment room a collection of high dust (grey fluff) was found on the light fitting in the room indicating that this was not cleaned regularly and in one of the consulting rooms we found that the window sill and work surface was dusty, indicating it had not been cleaned.
- The outpatient and diagnostic imaging departments main reception areas were visibly clean, tidy and free from clutter.
- There was hand sanitiser gel both outside the entrance to outpatients and on the reception desk. We observed both patients and staff using these upon entry to the department.
- Over the last 12 months there had been no reported cases of healthcare-associated infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff) or, Methicillin Sensitive Staphylococcus Aureus (MSSA) for the outpatients and diagnostic imaging department. These are all infections that could cause harm to patients.
- In radiology we saw a cleaning file for every room and this was signed as completed every day. The hospital's Patient Led Assessment of the Care Environment (PLACE) audit for 2015 showed the hospital scored the same or better than the England average for cleanliness, condition, appearance and maintenance.
- We saw hand hygiene audits for the hospital from April 2016 December and July 2015 where the score was consistently high (98% and above). Each of the audits had comments and action plans indicating where any issues were or areas for improvement.
- The patient toilets in outpatients were found to be clean, compliant and fit for purpose. The flooring and sinks inside this toilet were Hospital Building Note approved. Both had hand hygiene techniques posters displayed inside.
- We observed good use of safe sharps and self-sheathing needles in line with the EU Council Directive 2010/32/EU which is a directive implemented to prevent the sharps injuries in the healthcare environment. Sharps disposal bins were labelled correctly with the correct temporary closure used, apart from in one room where the temporary closure had not been fitted correctly.
- Personal Protective Equipment (PPE) including gloves and aprons were available in three of the outpatient consulting rooms inspected. The fourth room inspected had gloves available but these were stacked on the sink surrounding area rather than through a designated dispenser. We saw staff using PPE appropriately.

Good

Outpatients and diagnostic imaging

Environment and equipment

- Flooring in two of the rooms in outpatients department was non-compliant with Health Building Note (HBN) 00/10 Part A Flooring (DH 2013). 2.9 which states that there should be a continuous return between the floor and the wall, for example coved skirting with a minimum height of 100mm for easy cleaning. In the treatment room the coved edges were found to be damaged, and were coming away from the wall in some sections. This would be a collecting point for bacteria and could not be effectively cleaned. One of the consulting rooms had no coved edges and therefore a problem to effectively clean. The floor welding at the edges were also found to be coming away on one of the consulting rooms. We spoke to the general manager regarding these issues and were advised that these would be entered onto the risk register. They showed us the hospital's facilities action plan, which showed these areas were in the process of being addressed. On our unannounced visit we noted progress had been made against this plan.
- In the consulting rooms, there was a split between carpets and vinyl, which is contrary to the HBN 00/10 Part A 2.4 which clearly states 'carpets should be avoided in clinical areas'. When a member of staff was questioned on how a carpet with a spillage on would be cleaned we were told that the section of carpet would be removed and replace, which is not considered an effective infection control method. We spoke to the General Manager regarding these issues and were advised that these would be entered onto the risk register.
- Two of the sinks in outpatients were not compatible with HBN 00/09 Infection Control in the built environment (DH 2013). One was not an official hand sink) and had no mixer taps, and the other had an overflow hole. We spoke with the maintenance co-ordinator regarding these issues and were assured that the maintenance team were aware of the non-compliance. This was not logged on the risk register at the time of inspection. During our unannounced follow-up inspection, we saw this was placed on the risk register and we saw form plans that showed works to replace these had been expedited and were scheduled in the next few days
- In one drawer in the treatment room we found plaster scissors (a single use instrument) that should have been disposed of following their use. We asked the outpatient manager why they were stored there and if they were being used more than once which would mean that the instruments were being used outside of the manufacturer's recommendations and could result in cross contamination and a risk of infection for patients. The manager was not able to explain why these instruments were there but confirmed this would be stopped immediately and removed the items.
- Maintenance of equipment was managed by several different contractors. We asked the estates manager if we could have an overview of the equipment maintenance register but because this was managed by multiple contractors this was unable to be provided. It was therefore not clear what percentage of the equipment was up to date with maintenance. The estates manager was aware of this being a governance issue and has started a comprehensive spreadsheet of all the assets and equipment complete with maintenance dates due which should provide better assurance and overview in the future.
- The curtains in use within the consulting and treatment rooms were disposable and found to be in date, however two of the curtains were found to have stains on and should therefore have been replaced.
- The examination couches observed within the consulting rooms were wipeable and stocked with blue disposable towel. This meant that the couch could be easily cleaned between each patient.
- The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. Portable appliance testing (PAT) stickers were observed on most pieces of equipment. However some items had no PAT sticker or the expiry on the sticker was unclear. Examples of these were on the plug at the base of the crash trolley which had no PAT sticker, and several items of the laser equipment had PAT stickers but the date of next review due was a three digit number, not a date, and therefore unable to see whether PAT testing in date or not. The PAT label on the drugs fridge stated it was due for review November 2013 indicating that the fridge did not have an in date PAT certificate. This meant that the safety of these pieces of electrical equipment could not be guaranteed.
- There was a light box situated outside the treatment room which was switched on to indicate when the class 4 laser equipment contained within it was in use. We did not see this in use at the time of the inspection but

normally these would prevent staff or service users entering the room when potentially harmful lasers were in use. Class 4 lasers are capable of causing injury to both the eye and skin and will also present a fire hazard if sufficiently high output powers are used.

- There were lead gowns seen in radiology which protects staff member from radiation exposure, at the time of the inspection staff were not carrying out radiological procedures but staff were aware of the gowns and what they were used for. The assessment, revision and renewal of imaging services that are provided is considered good practice, The equipment in the diagnostic imaging department was on a capital replacement programme, with the X-ray unit due to be replaced in the next financial year.
- The provider had an appointed radiation protection supervisor (RPS) and a radiation protection adviser (RPA) in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations. This meant that the hospital had an independent annual audit of the imaging services.
- We saw copies of the independent annual audits (Radiation Protection Adviser audit) of the imaging services. We saw in the 2015 audit that an improvement was required around staff signing to say they were aware of the IRMER regulations and we found that this had been implemented.

Medicines

- The process for signing out prescription pads was that a maximum of 50 could be signed out by the Quality Improvement Lead and the log numbers of these and dates signed out were recorded in a log book which dated as far back as 2012. Once the prescription pads were signed out, they would remain on the outpatients department and be distributed amongst the consulting rooms in the morning, and collected back and stored in the locked drugs cupboard at the end of the day. Once the pads were signed out, there was no governance of how many forms were being used on a daily basis and could present a risk that any missing sheets may not be noticed and could lead to inappropriate use.
- We saw several blank prescription slips in one of the empty consultation rooms that was not in use at the time. The reception area outside the room was manned but could present a risk if a member of public or patient could gain access and remove the slips.
- There was a Service Level Agreement (SLA) in place for pharmacy cover at the hospital which is provided by Ashtead Hospital. The service is available 9 – 5pm Monday to Friday (except bank holidays) and an on call service is available outside of these hours. This meant that staff could access advice on medicines management at all times.
- Medicines that required refrigeration in outpatients were stored in a locked fridge, keys were held by the senior nurse and temperatures were checked and recorded daily. The drug fridge in the utility room was locked and the temperature was checked and logged daily. Records of this were seen back to November 2015 and there were contact details of who to call if the temperature readings were out of scale.
- Barium (contrast used for radiological procedures) was stored in a locked cupboard in the diagnostic imaging department and the keys for this cupboard were kept in the main office.

Records

- Patient records were managed in line with the corporate Medical Records Policy.
- The medical records office was in a temporary building separate from the main hospital building. Staff told us that the temporary building was locked when not in use and the key was kept at the main reception and signed in and out each morning and evening.
- Patient records in outpatients were paper based, however staff showed us that they could obtain some patient data electronically, for example if notes were lost and needed urgently for a clinic. Patient records were prepared the night before the clinic by the medical records team. These notes would then be brought up to outpatients in the morning before the clinic and stored in a locked filing cabinet behind the reception team. Staff told us only nurses had the keys for this cupboard which ensured their security when out of the records library. However, in one of the consulting rooms, we were able to access three handwritten notebooks containing patient information in an unlocked filing cupboard. Consultants, Administrative Assistants and staff at a wider focus group did not consider there were any problems with accessing patients' notes for their clinics. Temporary sets could be made up in extreme cases but they could not remember a time when

appropriate patient records were not available for an appointment. The trust told us their monitoring showed less than 5% of appointments occur without patient notes.

- A clinical coder attended weekly to code the NHS patient notes. Clinical coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format that is nationally recognised. This meant that any treatment carried out on an NHS patient could be entered into national figures for comparison and trends.

Safeguarding

- There have been no safeguarding concerns raised from the hospital since January 2015.
- Safeguarding adult policies were in date and procedures were accessible to staff in both outpatients and radiology. Staff could explain the process if a concern was identified.
- There were named safeguarding leads and these were displayed at various points around the hospital and staff were able to point these out to us in both outpatients and diagnostic imaging.
- Staff completed an on-line electronic learning training module as part of their mandatory training for safeguarding adults.
- Training records showed 100% of nurses in outpatients had received Level 1 Safeguarding training for vulnerable adults and that 67% had completed Level 2 safeguarding training. All radiology staff had completed Level 1 Safeguarding for vulnerable adults training. This was an appropriate level of training for vulnerable adults.

Mandatory training

- Compliance with the hospital's mandatory training amongst outpatient clinical staff was at 40% across five staff members; this was worse than the Ramsay Health Care Limited target of 90%. This meant that at the time of inspection, two members of staff were fully compliant with mandatory training, whilst the other three were booked onto sessions in the near future. As three members of staff had not received up to date mandatory training, the hospital could not be assured that the staff had received the most up to date raining available. We did not have access to mandatory training date for the administrative staff who worked on the outpatients and diagnostic imaging service but staff that we spoke to told us they received regular training.

Assessing and responding to patient risk

- We assessed two sets of female patient records in the diagnostic imaging department and both of them contained a signed form to confirm they had been asked about their pregnancy status and confirmed that they were not pregnant prior to radiological exposure in line with the hospital's pregnant women pathway.
- There was an emergency trolley and Automatic External Defibrillator (AED) in the main outpatients department. We saw it was, checked on a daily basis by reviewing the sign-off record.
- We saw a Management of Adult Medical Emergencies policy stored with the emergency trolley in outpatients. This was in date and was last reviewed in November 2014.
- The diagnostic imaging department did not have its own emergency trolley but the nearest one was located in the resuscitation lounge, along the corridor. The physiotherapy department did not have an emergency trolley but knew how to access this from elsewhere. The nearest one was located on the floor below in the main outpatient's area. This meant that in the event of an emergency or patient collapse, that staff would have to bring emergency equipment up the stairs or in the lift, which could delay timely treatment.
- The World Health Organisation (WHO) checklist for dermatology procedures was not fit for purpose as it did not specify the side of the patient the procedure was due to be carried out on or where the procedure needed to take place on the patient.

Nursing and radiology staffing

- All staff confirmed there were sufficient nursing staff to deliver care safely within outpatients and we observed this to be the case. The hospital told us that no shifts had gone below agreed staffing numbers.
- The hospital did not use a patient acuity tool to assess staffing needs in this service. They told us they reviewed patients' dependency and staffing levels in advance and throughout the day to ensure the patient needs are met. Records showed no agency nurses were used within outpatients in the previous year.

Good

Outpatients and diagnostic imaging

- There were no nursing vacancies in outpatients. The sickness rate for the whole hospital never rose above 6%. In outpatients and diagnostic imaging, sickness was normally be covered by ward nurses, the same applied for annual leave.
- In radiology we saw evidence of a competency and induction folder for new and agency staff. This meant that new and agency staff could integrate safely and efficiently into the workforce.

Medical staffing

- There were 128 consultants who had been granted practising privileges at the hospital, all of whom had been undertaking work at the hospital for over 12 months. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital.
- The hospital has a Resident Medical Officer (RMO) on site 24 hours a day, seven days a week to support the clinical team in the event of emergencies or with patients requiring additional medical support.
- The diagnostic imaging department had three radiologists with practicing privileges.
- If there are no patients and the hospital is closed, arrangements are made with Ashtead hospital to take any enquiries from patients who had attended outpatients and if necessary to see them to see them there. Consultants provided details of suitable cover arrangements as part of obtaining privileges and informed the hospital management of annual leave arrangements. We saw details of planned consultant absences and cover arrangements displayed for staff to reference.

Major incident awareness and training

- We observed a fire alarm test where one of the fire doors did not effectively close. We observed the estates manager noting this and we were informed later that this had been rectified.
- Six members of the outpatient department had immediate life support (ILS) training, and two members of the radiology department had ILS training. This meant that these members of staff could be called upon in event of a patient collapse or emergency situation with a patient, relative or member of staff.
- There were crash call buttons or cords in all of the consulting and treatment rooms in outpatients and diagnostic imaging and staff we spoke to told us they would use them in an emergency situation although they had not had to use them previously.
- There was a carbon dioxide fire extinguisher suitable for extinguishing electrical and liquid fires outside of the treatment room in outpatients which was tagged and in date. The chairs in the diagnostic imaging department waiting room partially obscured a fire exit; however there was sufficient room for a wheelchair to pass through in an emergency.

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Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effectiveness. However, we found:

- There was a good multidisciplinary team approach to care and treatment. Staff had the right qualifications, skills, knowledge and experience to do their job.
- Consent to care and treatment was provided in line with policy.
- There was awareness of relevant National Institute for Health and Care Excellence (NICE) guidance.
- The departments took part in local audits.

However, we also found:

- Not all staff had access to Mental Capacity Act or dementia training.
- There were low levels of staff appraisal, particularly amongst administrative staff.

Evidence-based care and treatment

- Staff told us they were able to access national and local guidelines through information folders held in the main outpatient's office and through the hospital intranet.
- Staff confirmed clinical governance information and changes to policies and procedures and guidance had been cascaded down by the outpatient manager via

emails and team meetings and we saw minutes from Clinical Governance Committee meetings where recent National Institute for Health and Care Excellence (NICE) NICE guidance was reviewed and discussed.
- We saw NICE guidance and protocols for procedures including trans rectal ultrasound (TRUS) biopsies and ultrasound joint injections in the diagnostic imaging department.
- We saw that the world health organisations (WHO) checklist was completed before ultrasound guided injections.

Pain relief

- None of the patients we spoke with required pain relief at the time of our inspection. Staff told us that they would escalate any concerns around pain relief to the Resident Medical Officer (RMO) or would use the emergency bells.
- One of the senior nurses described a recent incident where they noticed one of the regular patients appeared to be in pain when they entered the department and the patient confirmed they were not feeling well. The nurses escalated this and the Resident Medical Officer (RMO) was called who administered intravenous pain relief and the patient was transferred to the local acute trust for further management.

Patient outcomes

- The diagnostic imaging department audited Diagnostic Reference Levels (DRLs) for abdomen, chest and knee imaging. However, there were limited number of these to analyse due to the decline in number of X-rays requested compared to the increase in Magnetic Resonating Imaging (MRIs) requested which are performed at Ashstead hospital.
- The diagnostic imaging staff also told us they audited referral forms, non-radiologist reported imaging, post examination audits, environmental audits and radiographer hand hygiene audits which we saw. We reviewed the results of these and found these demonstrated that care was delivered in line with best practice.

Competent staff

- There were varying levels of staff appraisal across the outpatient department. During 2015, three out of the five members (60%) of clinical staff in the outpatient department had an appraisal, this was worse than the Ramsay Healthcare Limited target of 90%. One of the staff members who had not received an appraisal in 2015 had since had one in May 2016 and the outpatient manager told us that the remaining staff in the department all had dates booked for these.
- The level of administrative staff appraisals was not broken down to department level, but the hospital-wide figure for administrative staff was low at a reported 39%, this was worse than the Ramsay Health Care Limited target of 90%.
- However, administrative staff at a focus group told us they had all had an appraisal within the last year and spoke about the format of these and how their personal and team objectives are discussed as part of the appraisal process.
- There was 100% validation of professional registration for nurses working in outpatient departments who have been in post for 12 months and over. This means the hospital conducts annual checks to make sure all the nurses are registered with the Nursing and Midwifery Council (NMC) and is considered good practice.
- Consultants needed to provide evidence of appraisals and re-validation as part of their practicing privileges (PPs). There is a database which is maintained locally and is reviewed by the Group Medical Director. Where necessary there was communication between the Medical Director or Responsible Officer for Ramsay and the consultant's employer's counterparts.
- In diagnostic imaging, one of the radiographers was undertaking training to become a Radiation Protection Supervisor (RPS). This role is intended for the purpose of monitoring and securing compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- We saw new members of staff induction folder, which was comprehensive and interactive. The staff member had been assigned a buddy, and found the folder a useful guide for a new member of staff.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all staff in and outside the department. Staff reported they worked well as a team.
- Staff described an example of collaborative working where a patient required pain relief and transfer to the

acute trust for further management. Nurses from the ward attended to help from the ward and the consultant and RMO all supported to ensure the patient was kept safe.
- We saw physiotherapy transfers that had been made directly from the ward following surgery. This meant that patients could access post-surgery physiotherapy where appropriate in a timely manner to aid recovery.

Seven-day services

- Various outpatient clinics were operating between 8 am and 8 pm Monday to Friday with some clinics scheduled on Saturday mornings which enabled patients to attend the hospital at a time that suited them.
- Radiology services were available 8 am to 6 pm Monday to Friday, with evening clinics during the week when required and more complex imaging available at the sister hospital in Ashstead.
- The physiotherapy department provided services five days a week.

Access to information

- Hospital staff received medical information regarding NHS 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.
- Consultants, administrative assistants and staff at a wider focus group did not consider there were any problems with accessing patients' notes for their clinics. Temporary sets could be made up in extreme cases but they could not remember a time when appropriate patient records were not available for an appointment. The trust told us their monitoring showed less than 5% of appointments occurred without patient notes.
- Consultants showed us that they could call up diagnostic results on the hospital electronic systems if they were unable to access these via the patient notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 10 patient records during our planned inspection and unannounced inspection. These showed that consent was signed prior to procedure and on the day of procedure in line with the hospital's consent policy which had been recently reviewed.
- Some staff we spoke to had completed Mental Capacity Act and Dementia training and can described the process of how they would ascertain if a patient lacked capacity to consent, however not all clinical staff we spoke to had received this training.
- Staff were able to describe an incident where a young person with learning difficulties came into an appointment and the staff member felt that they lacked capacity. The parents disagreed with this and an arrangement was made for the consultant and nurse to visit the patient at their usual residence to try and ascertain capacity status. The outcome was that the patient was deemed not to have capacity and the parents were involved and happy with decision after careful liaison from the staff.
- Consultants told us that they rarely came in to contact with patients who lacked capacity due to the nature of their respective specialities but were aware of their responsibilities and the hospital processes for this.

Are outpatients and diagnostic imaging services caring?

Good

We have rated caring as good because:

- Feedback from patients who use the service, those who are close to them and stakeholders was positive about the way staff treated patients.
- Patients felt supported and said staff cared about them.
- Staff responded compassionately when people need help and support them to meet their basic personal needs as and when required. People's privacy and confidentiality was respected at all times.

However:

- The hospital achieved a below average response rate for the friends and family test.

Compassionate care

- The hospital took part in the friends and family test (FFT), a survey that asks patients whether they would recommend the service they have received to friends and family who need similar treatment or care. The response rate for NHS patients was low with only 28 patients taking part, and the response rate for private

patients was also low with only 12 patients responding. However, the patients who responded said that they would likely or extremely likely to recommend the service. We spoke to a patient in the waiting area who described their experience of the hospital as 100% satisfied and that they had never had a bad experience here.

- Staff told us they obtained patient feedback about their outcomes in a variety of ways such as the NHS Choices website. The NHS Choices website contained six ratings for 2016 but it was not possible to narrow these reviews down to outpatient and diagnostic imaging feedback. Of the six ratings given for 2016, five gave a five star rating
- One patient told us that "nothing was too much trouble" for the staff and that they would "absolutely recommend it"
- We spoke to an administrative member of staff who told us the best part of their job was working with patients. She gave an example of where a patient was extremely anxious and how she did everything she could to try and ensure the patient was seen quickly to ease her anxiety. This showed compassionate care.
- We saw an up-to-date Privacy and Dignity policy which staff were aware of and in the radiology department there were two changing cubicles seen with a curtain to promote dignity when changing into hospital gowns (one of which was used for storing equipment and therefore unavailable for patient use). However, the hospital's Patient Led Assessment of the Care Environment (PLACE) audit for 2015 showed they scored worse than the England average for privacy, dignity and wellbeing.
- We observed chaperone posters in visible areas around the outpatient department and inside the consultation rooms, for example there were posters above the examination couches. We also saw posters in the radiology department and staff showed us the hospital chaperone policy on their local intranet.
- Consultation rooms were private and could be used to speak with patients away from the waiting area if required.

Understanding and involvement of patients and those close to them

- We observed examples of compassionate care, an administrative member of staff on telephone to patient being very patient, empathetic and reassuring. We observed a member of administrative staff recognising that the reception area was very busy and offered a patient that they were dealing with a quiet place to talk.
- Staff introduced themselves with 'my name is' and we observed consultants introduce themselves and shake patients hands when they were called in for their appointment slot.
- We spoke to a member of staff about how they ensure all patients feel valued and they explained that all patients are treated and valued as individuals although they did note that self-funding patients do get an enhanced patient journey as they are not subject to NHS waits.

Emotional support

- Throughout our visit we observed staff giving reassurance to patients both over the telephone and in person.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Patients' needs were met through the way services were delivered and were planned and delivered to meet the needs of the local population.
- Patients could choose appointments that suited them.
- Care and treatment was coordinated with other services and other providers. Waiting times, delays and cancellations are minimal and managed appropriately and services ran on time.
- The provider exceeded national waiting time targets performing better than expected.

However:

- The provider did not keep a record of cancelled clinics and therefore was unable to understand why some people may not attend nor make any necessary adjustments to the service to improve attendance.

Service planning and delivery to meet the needs of local people

Good

Outpatients and diagnostic imaging

- The outpatient department worked 8 am until 8 pm Monday to Friday and also ran clinics on Saturday mornings. Evening and weekend appointments allowed patients who worked 9-5 Monday to Friday access to healthcare that suited their circumstances.
- The radiology department worked 8 am until 8 pm Monday to Friday and staff gave examples of being flexible to provide extra clinics or appointments to meet the consultant's requests or patient needs. The diagnostic imaging department carried out x-rays and ultrasound scans. Patients that required more complex tests such as magnetic resonance imaging (MRI) and computerised tomography (CT), scans are sent to North Downs sister hospital at Ashstead. This meant local patients needing complex imaging had to travel between North Downs and the sister hospital in Ashstead approximately 17 miles away. One patient we spoke with commented that they would like more complex diagnostic imaging available on site.

Access and flow

- The hospital exceeded the national target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period from January - December 2015.
- Patients accessed NHS services via a GP referral through the Choose and Book system, or via direct referral for private/self-funding patients or via their health care insurer.
- We spoke to a patient who regularly visited the hospital for appointments. They told us the longest they ever had to wait for an appointment is two weeks, but generally the wait is anytime between 48 hours and two weeks.
- On arrival, patients reported to the main reception where they would then be directed to the outpatients, physiotherapy or diagnostic imaging departments. The relevant receptionist at the front of department would then book them in via an online system and direct them to the waiting area or clinic room and we observed patients easily finding their way to their destination. There was sufficient space and flexibility for the number of patients being treated at the time of inspection.
- One of the consultants we spoke to said that the hospital was one of the best they had worked at in relation to patient flow and that the hospital was very proactive in the management of their patients.
- We observed administrative staff advising patients if there was a delay to their clinics and staff at a focus group confirmed they would always tell patients verbally as soon as they were aware of a clinic overrunning. We observed a consultant apologise for the delay when introducing himself to his patient.
- There were no available figures for outpatient and diagnostic imaging did not attend (DNA) rates, but staff at a focus group felt that there are more DNAs than there used to be and it tended to be NHS patients more than private patients. The radiology department have a three strike rule but staff told us they always contacted the GP when a patient fails to attend an appointment.
- The hospital did not keep a log of cancelled clinics or appointments. This meant the hospital could not fully understand why patients did not attend, or why clinics were cancelled and make any necessary changes to suit patients' needs if there were required.

Meeting people's individual needs

- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away and we saw staff including these leaflets in the letter envelopes to be sent out.
- A member of staff described an incident where there was an autistic patient that had come in for a consultation. The staff member used distraction therapy by looking through photographs with him whilst they were being examined. This meant that the patient was kept at ease whilst being examined and prevented any further distress.
- Whilst there were no specific bariatric chairs in the outpatient waiting area for bariatric patients, there were some chairs without arms that could be utilised for this purpose if required.
- The radiology department had introduced a 'blue pillow' scheme as a way for staff to discretely identify patients who may have memory problems or dementia. Staff covered the pillow with a blue pillow case as an indicator for staff. This meant that staff could tailor their interaction with the patient, knowing that they may have memory difficulties or dementia.
- Staff told us that they used a telephone translation service if they had patients who did not speak English as a first language. Staff told us that the need for translation services was flagged at the time of booking appointments.

Good

Outpatients and diagnostic imaging

- The hospital could be accessed by those who had a physical disability as there was a lift available to all floors, and a ramp at the front entrance of the hospital. Staff at a focus group spoke to use about planning and managing patients who have a physical disability or learning difficulty. These were flagged on the form when patients are booked in, and staff could arrange porter assistance for patients travelling alone or who may need more help.
- There were arrangements to ensure self-funding patients were aware of fees payable. A member of staff spoke to us about their role which included providing quotes and ensuring patients understanding of quotes. We saw information leaflets which gave an explanation to the pricing structure for self-funding patients and gave advice for who to contact if patients had any queries. The website also detailed different payment options for self-funding patients such as finance and pay as you go options and both were described clearly.
- There was reading material such as recent magazines and current newspapers for patients and their family to read whilst waiting for their appointment and we observed them doing so. There was also a radio on low volume in the background which promoted a relaxed environment for patients and relatives to wait in.
- There was a water dispenser and hot drinks machine in the outpatients waiting room. We observed patients using these and also staff offering to make drinks for patients/family members whilst in the waiting area. Staff at a focus group told us they often made drinks for patients whilst they were waiting and enjoyed the interaction this brought. A review on NHS Choices referred directly to the staff making a patient's relative a drink whilst in the waiting room and how much this was appreciated.
- We saw that free Wi-Fi was available which enabled patients and relative to access the internet via their smart phones whilst in the waiting room.
- There was sufficient free parking to meet patients' needs throughout the duration of our inspection.

Learning from complaints and concerns

- The hospital had clear processes in place for dealing with complaints. Patients we spoke with understood how to complain. Staff were aware of the complaints process and were able to discuss changes of practice with us that had occurred following complaints investigations.
- The hospital followed their corporate complaints policy for managing complaints. The policy was due for review in April 2016 and at the time of our inspection the policy was under review.
- There was a procedure within the policy that set out necessary steps to be taken upon receipt of an informal or formal complaint. We saw evidence of learning from complaints and staff were able to describe learning, an example given was the introduction of the blue pillow case to identify dementia patients, after a compliant and incident review.
- Complaints and identified themes were discussed in the monthly Clinical Governance Committee meetings and we saw the minutes of these meeting to confirm this. Department specific complaints were discussed within teams. Complaint themes were also discussed with department managers at hospital leadership team meetings.
- The general manager undertook overall responsibility for responding to all written complaints. The hospital's aim was to provide written acknowledgement within two working days of receipt of a complaint and provide a full written response within 20 working days when the outcome of the investigation was known. These targets were being met.
- CQC directly received no complaints in the period January - December 2015. We noted the number of complaints increased annually since 2013. We are unable to explain if this was as a result of better complaints handling or decreased satisfaction. The hospital received 75 written complaints between January 2015 and April 2016, 26 of which related to outpatients and diagnostic imaging. At the time of our inspection one of these complaints was open awaiting further action. We noted that the themes arising from the varied complaints were attitude of nursing staff and consultations in OPD.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- The leadership, governance and culture promoted the delivery of high quality person centred care.

Good

Outpatients and diagnostic imaging

- The hospital had a clear vision and values, driven particularly by respect and integrity.
- Staff were focused on providing the best service they could for all patients whether they were self or NHS funded.
- There was positive engagement of staff and patients. Staff were aware of their responsibility to escalate identified risks and knew of the Risk Management policy and risks for outpatients was logged onto the hospital's electronic reporting system.

Vision and strategy for this this core service

- There was no specific strategy for the outpatient and diagnostic imaging department, however there was a corporate level statement of purpose, which listed effective organisation, conducting business with integrity and providing the highest quality of care as some of their strategic priorities. The provider's own Patient's Charter stated that care will be delivered to patients in privacy, with compassion, dignity and respect.
- Staff at a focus group talked enthusiastically about the 'Ramsay Way', which was a corporate set of values for patients and staff. This showed staff were aware and understood the values and behaviours the organisation expected of them.
- The website for North Downs talks about the 'Ramsay Way' and specifically about North Downs values including a 'positive spirit to get things done'. We observed a positive spirit from all of the staff whilst inspecting the service and one patient we spoke to commented that the staff "seem happy to work here."

Governance, risk management and quality measurement for this core service

- The hospital held meetings through which governance issues were addressed. The meetings included the Medical Advisory Committee (MAC) meeting, Heads of Department (HOD) meeting, Senior Management Team (SMT) meetings and the Clinical Governance Committee.
- The MAC was due to meet quarterly but there were only three meetings in 2015 as one meeting was not quorate. The minutes from the last two MAC meetings supplied by the hospital for June and October 2015 demonstrated that key governance areas were discussed including training, risk assessments, clinical incidents, never events and complaints.
- The HOD met monthly and discussed items including action plans, hospital activity, risk registers and business plans. We saw evidence of these meeting minutes.
- The SMT meetings looked at high level issues and a report was produced from these meetings to be discussed in the HOD meetings.
- Monthly Clinical Governance Committee meetings and discussed incidents, complaints, infection control issues and gave each department an opportunity to discuss relevant governance issues.
- There was a corporate risk management policy which was in date and outlined expectations for all staff to work in a manner which reduces risks and to escalate potential risks through the management structure.
- There was system of governance to monitor, identify and mitigate risk. Although the hospital had showed us evidence of risk assessments and a risk logs for each department, risks from clinical departments were not entered on the risk register, which during our inspection had only corporate risks included. This meant that there was no clear governance around clinical departmental risks.
- We did not see a risk register for the outpatients department, however, we saw evidence of up-to-date risk assessments and risk log with appropriate mitigations in place. These were completed for risks such as latex allergies in outpatients, sharps injuries and blood spillage and we saw evidence that staff had signed as reading these risk assessments.
- There was a morning 'huddle' held on a daily basis. This was an informal meeting held at the start of each working day where the Heads of Department came together to discuss potential issues for the day. During our inspection we attended the morning 'huddle'; it was very efficient way of starting the working day. There was a brief overview from the night staff and brief discussion of the plans and any potential issues for the day including staffing or changes to consultation's list.

Leadership/culture of service

- We found that outpatients and diagnostic services provided by the North Downs Hospital were good overall although some aspects of safety required improvement. This was because the service took care in ensuring the safety of patients, staff and secured

positive patient outcomes. We noted the concerns about environmental issues raise during our announced visit were being addressed promptly when we made our unannounced visit.

- We saw strong leadership at the location with an open and transparent culture. The registered manager used governance and performance management to maintain and improve the quality of the service.
- Staff were overwhelmingly positive about their experience of working at the hospital and showed commitment to achieving the provider's strategic aims and demonstrating their stated values. Staff told us they were supported by general manager who was visible and approachable. They described an open culture with an emphasis on delivering the best care possible.
- The low staff turnover (less than 20% hospital-wide) reflected the positive regard in which staff held the service and their colleagues. There were high levels of staff stability of equal to or greater than 80% for health care assistants and nurses working in the outpatient department and there were no vacancies in these areas.
- Staff told us their immediate line managers and senior managers were very approachable and supportive. Staff at a focus group told us that it was refreshing to be able to knock on a senior managers door and that there was an open door policy for all staff. They also spoke of the hospital being very family orientated, and that they experienced good rapport with all of their colleagues.
- Staff told us that they would feel happy speaking to senior management or the corporate Human Resources (HR) department if they were unable to speak to their direct line manager.

Public and staff engagement

- We spoke to members of staff who sat on the Patient Focus Group and were proud to be involved in this group as they get to see outcomes from complaints and helps them to know where they can improve. An example of this was that patient perception of handwashing was still quite poor and so they get the opportunity to discuss how to make this more visible and to encourage patients to notice. Patients are also invited to attend this meeting and are able to discuss how incidents or complaints affected them.
- Staff told us about being involved in a public information and marketing evening for the hospital and really enjoyed the chance to be involved in this and to help publicise a hospital that they are proud to work in.
- Staff spoke highly of the flexibility offered by the hospital. Examples given included the support given to staff when returning to work staff being supported when coming back to work from having a child.
- There is a Ramsay Wellbeing Scheme which staff at a focus group told us about. The scheme offered assistance and support in areas such as physiotherapy or counselling which some members of staff have utilised and benefitted from.
- Staff at a focus group spoke enthusiastically about staff forums where they have the opportunity to discuss the hospital vision. These informal meetings occur every two to three months, and they are shown some key data about recent hospital activity, and have the chance to share ideas. Staff commented that this was about focussing on what they do well, and how best to go forwards in the future in terms of strategy.
- Staff told us that there was a list of Friends and Family test (FFT) results in the lunch room which was useful for them to see.

Innovation, improvement and sustainability

- Staff at a focus group spoke about the introduction of a new Electronic Patient Record (EPR) system which is due to be trialled in September, and some of the staff present had been given a chance to trial it.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Improve compliance with its mandatory training programme.
- Store medical gases securely.
- Ensure sufficient controls are in place for the monitoring and provision of prescription pads in the out-patient department to minimise the risk of mis-use.
- Ensure first assistants have the necessary skills and competence to carry out their roles.

Action the provider SHOULD take to improve

- Carry out planned works without delay to ensure clinical areas comply with Health Building Note (HBN) 00/10 Part A Flooring (DH 2013)
- Review the arrangements for Portable Appliance Testing it ensure it is consistent and that all relevant electrical items carry a certificate of testing notice.
- Assess the risks of the use of oxygen cylinders and the absence of piped medical gases.
- Consider the arrangements that ensure the completion of action points following learning from an incident.
- Review the use of latex gloves in theatres

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (2) (c) Safe Care and Treatment: Ensuring that person providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely Mandatory training rates were 40% for outpatients and 66% for surgery, which meant persons may not have the necessary competence and skills to carry out care safely. The hospital could not be assured of the skills, qualifications and competence of first assistants.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (2) (g) Safe Care and Treatment: the proper and safe management of medicines Medical gases were not stored securely. There were inadequate systems to prevent the mis-use of prescription pads in the out-patient department.