

# Renacres Hospital

## Quality Report

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Date of inspection visit: 19,20,25 July

Date of publication: 28/12/2016

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

### Ratings

#### Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Renacres hospital is an independent hospital, based in a rural location near Southport and is part of Ramsay Health Care UK. Renacres hospital is registered to provide the following regulated activities:

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

Our key findings were as follows:

- Safety Thermometer information between June 2015 and June 2016 showed there were no pressure ulcers, falls with harm or catheter urinary tract infections reported by the hospital relating to surgical services.
- Systems were in place to protect people from healthcare associated infections. There had been no cases of MRSA or clostridium difficile at the hospital. There was a lead nurse for infection control that was given protected time in her job role. There were monthly infection prevention audits and hand washing audits
- Staffing levels were good at the hospital and sickness levels were low. Use of agency staff was low as there was a bank of existing staff that were happy to work additional hours. There was a corporate workforce policy, though senior managers felt that it needed to be strengthened to retain and recruit nursing staff. The Ramsay group was looking at international recruitment for nurses. However, skill mix was not always appropriately used at the hospital. In theatre some of the health care assistants had been trained as first scrub assistants but elsewhere in the hospital there were fewer opportunities. On the ward, trained nurses were cleaning equipment and in the OPD blood was taken by trained nurses. These tasks could be delegated to lower banded staff following appropriate training and competency assessment.
- Mandatory training levels were good; the hospital informed us that all eligible staff had completed their training. We were shown a completed training matrix for staff and signing in sheets for the face to face sessions.
- The (resident medical officer) RMO was available 24 hours a day seven days a week and had full access to the consultant surgeon and anaesthetists details. Nursing staff said that they worked well with the RMO but if they had concerns they would contact the consultants directly.
- There were robust systems in place to ensure that information was communicated with the patients GP.
- There was a clear patient exclusion criteria to identify patients who were not suitable for surgery at Renacres hospital.
- The hospital had a 'management of patient complaints' policy in place. The rate of complaints received was lower than other independent hospitals. No complaints progressed to the Ombudsman or to ISCAS (Independent Healthcare Sector Complaints Adjudication Service), or were received by CQC in this period.
- There was a corporate risk register. The current register recorded 10 risks; six of which related to financial risks. The remainder included a number of risks that were not relevant or of very low risk to Renacres hospital. The risk registers were an agenda item on the health and safety committee, which was not attended by the MAC chair; this meant that there was no clinical ownership of risk. Risks were reviewed annually. There were risk registers for clinical areas, some of these had review dates and actions and others did not. Risks were reviewed at the health and safety meetings and did not feed into the corporate risk register.

# Summary of findings

- There was a policy in place for the granting of admitting rights and/or practising privileges to health care professionals. Compliance with the policy was mandatory for all consultants, staff and accredited healthcare professionals and approval needed to be granted at a local and national level. Consultants could only practice at the hospital what they practiced in the NHS and the MAC chair would look at the number of procedures that had been carried out in the NHS and the training logs of the consultants, he would also look at local data available on the consultants e.g. complication rates and infection rates
- Consultants had to provide evidence of revalidation and indemnity insurance. If they did not, payments were withheld The MAC chair was about to start the appraisal training so that he could undertake consultant appraisals.
- Some of the consultants did not work in the NHS, including the MAC chair; he discussed the robust processes for revalidation and appraisals. Although the hospital were keen to recruit new consultants, the MAC chair said that he would be comfortable refusing a potential new consultant practising privileges if necessary.
- The MAC chair audited consultants practice and could benchmark this against other consultants in the Ramsay group and identify individual consultants who were outliers. He was proud of his service and the level of governance at the hospital.
- The hospital had a responding to concerns about a doctor's practice policy in place. It set out the actions to be taken when concerns were raised about any GMC registered doctor in the hospital. The policy did not set out any details about informing other local healthcare providers about the concerns but the MAC chair said that he would always write to the medical director of the employing trust outlining his concerns if there were any issues about a doctor and he gave us a specific example where this had happened.
- Staff could be nominated for customer service excellence awards, these were for staff who had gone the extra mile in their work, we saw three nominations for staff working at Renacres.

Professor Sir Mike Richards

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Surgery

### Rating Summary of each main service

Good



Patient safety at the hospital was monitored, incidents were reported and the learning from incidents was used to improve patient care. Staffing levels met the patients' needs and there was good multi-disciplinary team working. Medicines were stored safely and the environment was clean and records were stored securely.

Patients received care and treatment according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. Surgery services participated in national audits.

Patients spoke positively about their care and all patients were treated with privacy and dignity. The hospital was meeting national targets for referral to treatment times and processes were in place to support vulnerable patients. Complaints were dealt with efficiently.

Governance structures were good and there was effective teamwork with visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.

#### Outpatients and diagnostic imaging

Good



People who used the services were protected from abuse and avoidable harm and staff were aware of the processes and reporting systems for recording incidents and safeguarding concerns. Staffing levels were sufficient to provide care in a safe way and staff appropriately responded to changing risks. Hygiene and infection control practices were followed. Patient records were held securely.

The care and treatment provided to people was evidence based and in line with relevant standards and legislation, including National Institute for Health and Care Excellence (NICE) and professional organisational guidelines.

Staff provided care and treatment to people who used the services in a caring and compassionate way and people were involved in decisions about their care. Translation services were available to people as necessary

# Summary of findings

The hospital planned the services to meet the needs of the local population. Waiting times for initial assessment, and treatment, following referral were low, and the services met the waiting time targets. Staff treated people as individuals, and made appropriate adjustments as necessary.

There was a robust governance framework and strong management and leadership within the hospital. A comprehensive audit programme and a risk register were in place.

There was good staff engagement within the services and staff felt supported by the management team.

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# Summary of findings

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Good 

# Renacres Hospital

**Services we looked at**

Surgery; Outpatients and diagnostic imaging.

# Summary of this inspection

## Background to Renacres Hospital

Renacres independent hospital is part of Ramsay Health Care UK, who are the fourth biggest provider of independent health in the world. There are a number of Ramsay hospitals in the United Kingdom and three in the local area

The hospital has a ward area with 23 inpatient beds and an additional six mixed use beds for day cases or inpatients. We inspected the OPD and radiology services in the hospital but we didn't inspect the mobile magnetic resonance imaging (MR) and computerised tomography (CT) scanning service because it was registered and provided by another provider. The inspection was part of our ongoing programme of comprehensive independent health care inspections.

The hospital has a rural location and is close to Southport which has an ageing population. Southport has a district general hospital. There is a low black minority ethnic (BME) population most of who are Eastern European who work in the service industry and agriculture. It is also close to Skelmersdale which is an area of deprivation. Skelmersdale has a walk in centre. There is also a low BME population in Skelmersdale.

The registered manager had only been in post for five weeks at the time of the inspection but the previous registered manager was present for the duration of the inspection. She has moved to another Ramsay hospital in the area.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, 3 other CQC inspectors, and specialist advisors including a lead nurse with experience of

working in a post anaesthetic care unit; a radiographer and clinical tutor/ honorary lecturer and a managing director and non-executive director. The inspection team was overseen by Ann Ford, Head of Hospital Inspection.

## Why we carried out this inspection

The inspection was a planned comprehensive inspection which was part of our scheduled programme of inspections of independent health.

## How we carried out this inspection

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

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

The hospital provided us with comprehensive information and data before the inspection and we also used information from patients and the public including patient survey data and feedback from patients who had received treatment at the hospital. We looked at information from healthwatch and from the commissioners of the services. Some data was available nationally including friends and family data.

During the inspection on the 19, 20 July 2016 we spoke with senior managers and a range of staff, including consultants, who worked at the hospital. We held a focus



# Summary of this inspection

group on both days of the inspection; these were open to all staff members and in total and were attended by 38 members of staff which was over one third of the workforce. Several staff, including some of the night staff, came into the hospital specifically to attend the focus groups. We spoke with a number of patients who were attending the hospital at the time of our inspection and

we collected four “tell us about your care” cards from the reception area at the hospital and we reviewed a number of patient records. We viewed policies and standard operating procedures.

On 25 July 2016 we conducted the unannounced inspection. Following the inspection we requested additional information which was provided in a timely manner.

## Information about Renacres Hospital

- The services provided by the hospital included : audiology, cardiology, cosmetic surgery, dermatology, ear, nose and throat, (ENT), general medicine, general surgery, gynaecology , nephrology, neurology, neurosurgery, ophthalmology ,orthopaedics , pain management, podiatry, psychology, physiotherapy, rheumatology, sports medicine, urology and vascular.
- There were 23 in-patient beds and six day case beds in ambulatory areas which were in bays of three.
- The theatre department comprised of two main operating theatres (one with laminar flow) and an endoscopy unit.
- There were 697 inpatient attendances and 5,394 day case attendances at the hospital between April 2015 and March 2016. Approximately 89% of surgical patients attending the hospital underwent day surgery.
- The majority of patients (86%) were NHS funded patients and the remaining 14% were privately funded.
- The out-patient department had nine consultation rooms including specialist ENT and eye rooms. In addition, there was a room designated for pre-operative assessments and a sound-proofed audiology room.
- Between April 2015 and March 2016 there were 43,169 outpatient attendances at the hospital. 77% of attendances were NHS funded, and the remainder were privately funded.
- The radiology department had its own waiting area which was shared with physiotherapy. There was mobile computerised tomography scanning (CT) and magnetic resonance scanning (MRI) on site each week. The procedures carried out in the radiology department included plain x-ray, ultrasound, urodynamics and out-patient injection procedures.
- The physiotherapy department was located on the ground floor. It included two individual treatment rooms for treatment of out-patients and a small rehabilitation area. The physiotherapy team also supported orthopaedic in-patients.
- The accountable officer for controlled drugs was the matron.

# 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?

We found services to be safe at Renacres hospital,

- this was because systems and processes were in place to report incidents and to ensure learning from these incidents. During the inspection we saw letters to patients that outlined the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There was a lead nurse for safeguarding and staff had received training in safeguarding for vulnerable adults for children and young people. No safeguarding concerns had been raised. All eligible staff had attended mandatory training.
- Systems were in place to protect people from the risk of healthcare related infections and there were no reported healthcare related infections at the hospital in the period April 2015 to March 2016 and there were no reported incidents of acquired venous thromboembolism or pulmonary embolism in the same period.
- The environment was visibly clean and tidy and there were audits every six months. Action plans were in place, if appropriate and were reviewed.
- Records were kept securely and consultants were not allowed to remove records from the hospital. Records removed from the hospital to the GP surgery outreach clinics were transported in lockable boxes.
- Medicines were stored appropriately and there were pharmacy audits and controlled drugs audits completed.
- Staffing levels were planned and implemented to ensure that there were sufficient staff to provide safe care. This included the resident medical officer (RMO) cover. There was very low use of agency staff.
- However, there had been one never event, these are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented. This had involved wrong site surgery and a root cause analysis had been carried out and lessons learned by the organisation.

Good



# Summary of this inspection

## Are services effective?

Good



We found services to be effective at Renacres hospital ,

- this was because patients received care and treatment according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges.
- The chair of the medical advisory committee (MAC) was extremely efficient and described robust practising privileges processes. The MAC met every three months, had well-structured agendas with items including National Institute for Health and Care Excellence(NICE) guidelines, consent, audits, complaints and policies. Meetings were well attended with consultants from the range of specialities provided at the hospital and by the matron and the registered manager. The MAC chair was a member of the clinical governance committee at the hospital linking the MAC to the hospital. Consultant revalidation processes were good with evidence of revalidation kept by the hospital.
- The hospital participated in the national joint registry and the Joint Advisory Group for endoscopy accreditation scheme (JAG GRS) and they reported on PROMS from patients for hip and knee replacement and groin hernia. PROMS are patient report outcome measures which describe the level of patient satisfaction and in the period April 2014 and March 2015 the percentage of NHS-funded patients with improved outcomes following groin hernia, hip replacement and knee replacement procedures was similar to the England average
- Renacres was part of a standard NHS contract with two other North West Hospitals in the Ramsay group. There were commissioning for quality and innovation commissioning (CQUIN) targets in place. The results enabled them to monitor performance compared to the other two local Ramsay hospitals. e.g. advancing quality audits for hips and knee joint replacements. There were low rates of unplanned readmissions to theatre within 28 days of discharge; there had been four in the period April 2015 to March 2016. There had also been two unplanned returns to the operating theatre in the same period.
- There was a recently established continuous improvement working group. This multi-disciplinary group had representation from across the hospital with a focus on quality improvement, performance monitoring and improving the patient experience.

# Summary of this inspection

- Multi-disciplinary working was good and there was effective communication between different staff groups. There were good consent processes in place and staff were aware of the policies and processes of the mental capacity act and best interest meetings were used as appropriate.
- The copy of the consent policy that we reviewed expired in January 2016.

## Are services caring?

We found services to be caring at Renacres hospital,

- this was because we observed that patients were treated with kindness and compassion by all staff. Feedback from patients was very positive and they informed us that they were fully involved in their care and that staff explained procedures to them. Patients told us that they were treated with kindness and compassion by all staff and spoke positively about the care they received and were fully involved in their care and staff explained procedures to them. Privacy and dignity was respected at all times. Patient's relatives and carers were involved in consultations when appropriate.
- In the friends and family test in the period October 2015 to June 2016 the hospital frequently scored 100% with responses above the England average, these ranged between 55% and 96%. In the hospital's own patient satisfaction survey over the past year the lowest score was 93.9% and the highest was 100% for two months.
- Healthwatch had undertaken a patient experience survey in November 2015 and the hospital had scored highly for care and compassion, 4.8 out of 5. A patient said it was an excellent service another said the service was fantastic.
- There were examples where staff had gone the extra mile for patients; taking medicines to patient's homes on the day of discharge so that they would not have to wait for them and also taking items that patients had left at the hospital to their homes to prevent an additional trip to the hospital. The catering team would go onto the ward if patients had not eaten their meals to find out if there was anything that they could make for the patient and if so this would be prepared for them.

Good



## Are services responsive?

We found services to be responsive at Renacres hospital,

- this was because the hospital was meeting national referral to treatment targets in OPD and surgery. No NHS patients were waiting longer than six weeks for magnetic resonance imaging

Good



# Summary of this inspection

(MRI), computerised tomography (CT) scanning, non-obstetric ultrasound, colonoscopy, flexible sigmoidoscopy and gastroscopy OPD diagnostic investigations between April 2015 and March 2016.

- Services were planned and delivered to take account of the needs of vulnerable people and reasonable adjustments were made as necessary. Chaperones were available as necessary and there were posters informing patients of the availability of chaperones
- Waiting times at the hospital were very short and patients were seen very quickly, following arrival. Did not attend rates were very low and very few clinics were cancelled. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to support learning. Translators were accessible and information leaflets were available in large print, in other languages and in braille.
- There was a dementia champion and the hospital had introduced training for staff. The hospital was participating in a Commissioning for Quality and Innovation (CQUIN) with the other local sites, regarding dementia friendly care.
- There will be three inpatient rooms that will be dementia friendly; the hospital was working with the Alzheimer's society to provide guidance on how to do this.

## Are services well-led?

We found services to be well-led at Renacres hospital,

- this was because there was an annual corporate strategy for the hospital with local actions. The staff knew the corporate provider's 'Ramsay' way values which related to being caring and progressive, taking pride in achievements, recognising and encouraging staff, building constructive relationships and maintaining a sustainable and profitable organisation.
- There were good governance structures in the organisation with an effective MAC chair and MAC committee, there were committees for medicines management, infection control and health and safety feeding into the clinical governance committee and medical advisory committee (MAC).
- There were robust procedures in place for the monitoring, agreeing and reviewing of practising privileges and the performance of the consultants.
- There was a comprehensive audit programme at the hospital. Results were discussed at the relevant committees and any risks arising from these were put on the risk register

Good



# Summary of this inspection

- There was a corporate risk register and risk registers for each clinical area. Risk management was an agenda item on the health and safety committee however as the MAC chair did not sit on the health and safety committee there was no clear clinical ownership of risk.
- There was an open culture at the hospital and the staff were happy to work there, this was demonstrated through the staff survey as results were very positive and Renacres had scored better than the other Ramsay hospitals.
- Patient engagement was good. Managers were very visible and the matron and the registered manager did a walk round of the hospital every morning.
- All staff had completed their appraisals at the time of the inspection; appraisals had to be completed by July as salary increases were dependent on a completed appraisal.
- The hospital was completing the workforce race equality standard (WRES) reporting template.
- The hospital wanted to improve on what they did and was not looking to provide additional services that carried more risk due to their rural location.






# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

# Surgery

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

## Are surgery services safe?

Good 

We rated Safe as 'Good' because: -

### Incidents

- The surgical services reported one 'never event' between April 2015 and March 2016. A 'never event' is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- The 'never event' related to an ankle block injection administered to the wrong side ankle (wrong site surgery) in October 2015.
- The incident was investigated and the root cause was determined to be 'human error' as the consultant anaesthetist did not stop to check the site of injection before administering the injection. The investigation noted that the hospital's procedures were followed correctly during the remainder of the process and that NHS 'stop before you block' posters were also in place at the time of the incident.
- Remedial actions following the incident included reflective learning from the consultant involved in the incident and sharing the incident findings with the theatres teams to aid their learning.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation and we saw evidence to show duty of candour principles were appropriately applied following the 'never event' incident.

- The hospital reported there had been no serious incidents relating to surgery between April 2015 and March 2016.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the hospital's electronic incident reporting system. Complaints and allegations of abuse were also logged on the electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by the ward and theatre managers to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matron.
- Staff told us that incidents and complaints were discussed during daily handovers and monthly staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at. A 'lessons learned' sheet was used by staff to discuss specific issues.
- The hospital reported there had been no patient deaths relating to surgery between April 2015 and March 2016. There was a process in place so that if a patient death occurred at the hospital, it would be reviewed and investigated through the hospital's medical advisory committee (MAC).

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

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).



# Surgery

- Safety Thermometer information between June 2015 and June 2016 showed there were no pressure ulcers, falls with harm or catheter urinary tract infections reported by the hospital relating to surgical services.
- The hospital reported that it had carried out venous thromboembolism (VTE) risk assessments for 100% of its patients between April 2015 and March 2016. There had been no cases of hospital-acquired VTE or pulmonary embolism (PE) reported by the hospital during this period.
- The patient records we looked at showed that VTE risk assessments had been carried out prior to patients undergoing surgery and patients identified at risk were placed on care pathways to manage the risk of acquiring VTE.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- All patients admitted underwent MRSA screening. Patients identified as at risk were also screened for Carbapenemase-producing Enterobacteriaceae (CPE) infections. Patients identified with an infection could be isolated in their rooms to support the management of cross infection risks.
- Staff carried out routine scheduled infection control audits covering key processes such as hand hygiene compliance, surgical site infection management, urinary and central line catheter care bundle compliance and infection control equipment and environmental audits.
- Hand hygiene audit and environmental results were carried out every three months. Audit scores for October 2015 (88%) and December 2015 (96%) showed there was good staff compliance with hand washing conduct and technique. However, the overall audit score was affected by issues such as a hand hygiene guidance poster not being in place and patients and visitors not given hand hygiene information leaflets. Remedial actions had been put in place to address these issues and an improved compliance score of 99% was achieved in April 2016.

## Cleanliness, infection control and hygiene.

- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C. diff) or Escherichia coli (E. coli) at the hospital between April 2015 and March 2016.
- The hospital reported they had eight surgical site infections (SSIs) between April 2015 and March 2016. The infections were attributed to a range of surgical procedures and there were no recurring infections or trends that could attribute to the infection rates. The rate of surgical site infections at the hospital was similar to the rate for NHS hospitals.
- Each incident was investigated to look for improvements to the service. We looked at the investigation reports for two surgical site infections. These showed that appropriate remedial actions were taken to minimise infections, such as wound assessment training for staff.
- The preoperative assessment area, ward and theatre areas were clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.

## Environment and equipment.

- The preoperative assessment area, ward and theatre areas were visibly clean, well maintained and free from clutter.
- All the equipment we saw was visibly clean and well maintained. Staff told us that all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- Equipment servicing was managed by a centralised maintenance team that arranged for equipment to be serviced by external contractors. Equipment such as hoists, operating theatre equipment and blood pressure monitors included labels showing they had been serviced and when they were next due for servicing.
- Reusable surgical instruments were sterilised in a dedicated sterilisation unit by an external contractor. Single use sterile instruments were stored appropriately and kept within their expiry dates.
- Reusable endoscopes (used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room. The facility had

# Surgery

achieved joint advisory group for gastrointestinal endoscopy (JAG) accreditation during 2014. We saw that scopes were decontaminated in accordance with best practice guidelines with a segregated clean and dirty area and use of a coding system for traceability.

- The hospital had an agreement in place with a neighbouring NHS acute trust for the supply emergency blood if needed. Eight units of O negative blood were kept on site in a dedicated fridge and staff carried out daily checks to ensure this was stored appropriately and kept within expiry dates.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff across the surgical services and responded to in a timely manner.
- Emergency resuscitation equipment was available across all areas and checked on a daily basis by staff.

## Medicines.

- The hospital had an arrangement with a neighbouring NHS acute trust for pharmacy support. As part of this arrangement a pharmacist, a pharmacy technician and all medicines were supplied by the acute trust.
- The pharmacist was on site for two hours per day during weekdays. The pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The pharmacy technician was on site two days per week to replenish medication stocks and check expiry dates.
- The pharmacist carried out scheduled medication controlled drugs and prescribing audits. Medication audit results over the past 12 months showed compliance levels of 90% and above were consistently achieved in the ward and theatre areas.
- The pharmacist was available on-call outside of normal working hours and at weekends. Staff told us they received good support and had timely access to medicines needed for patients outside of normal working hours and at weekends.
- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- Medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.

- We looked at the medication charts for four patients and found these to be complete, up to date and reviewed on a regular basis.

## Records.

- The hospital used paper based patient records and these were securely stored in each area we inspected.
- We looked at the records for eight patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for patient falls, venous thromboembolism (VTE), sepsis, pressure care and nutrition and these were completed correctly.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.

## Safeguarding.

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction followed by refresher training every three years. The hospital reported that all eligible staff across the surgical services had completed their safeguarding training to level two for safeguarding for children and young people.
- Staff were aware of how to identify potential abuse and report safeguarding concerns. Information on how to report safeguarding concerns was clearly displayed in the areas we inspected.
- The hospital had named safeguarding leads for adults and children's safeguarding and staff aware of how they could seek advice and support from the named leads when needed.
- There had been no reported safeguarding incidents relating to surgery at the hospital between April 2015 and March 2016.

## Mandatory training.

- Staff received core mandatory training in key areas such as children and adults safeguarding, infection control, fire safety, equality and human rights, manual handling, information security, resuscitation and moving and handling training. All eligible theatre staff were at 100% compliance with their mandatory training.
- Staff in the wards and theatre areas also received clinical mandatory training in areas such dementia care, intravenous drug administration, taking bloods, consent and life support training.

# Surgery

- The mandatory training was delivered either face-to-face or via e-learning. The hospital reported that all eligible staff across the surgical services had completed their mandatory training

## Assessing and responding to patient risk.

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues and there was daily involvement by the ward and theatre managers and the matron to address these risks.
- Prior to undergoing surgery, staff carried out preoperative risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify patients with any medical conditions or those deemed at risk of developing complications after surgery and a decision was made whether they could be operated on at the hospital.
- Staff used early warning score systems and carried out routine monitoring based on the patient's individual needs to ensure any changes to their medical condition could be promptly identified.
- A care of the deteriorating patient audit carried out in April 2016 showed 97% compliance was achieved. This showed staff used early warning scores and escalated appropriately.
- Where a patient's health deteriorated, staff were supported with medical input to stabilise patients prior to transfer. The hospital was a member of the Cheshire and Mersey Critical Care Network and had a transfer agreement in place with the network to ensure patients could be transferred to a local acute trust if needed.
- There had been seven unplanned transfers of surgical patients to other hospitals between April 2015 and March 2016. The rate of unplanned transfers at this hospital was similar to other comparable independent acute hospitals.
- We looked at the records for the unplanned transfers. In each case, the decision to transfer was made by a clinician for valid clinical reasons and the patients were transferred in accordance with the hospital's policy for transferring critically ill patients.
- We observed six theatre teams undertake the 'five steps to safer surgery' procedures, including the use of the

World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.

- An audit to monitor adherence to the WHO checklist took place every three months by observing practice and reviewing completed records from a sample of ten patients across the theatres department.
- The WHO audit reports from August 2015 to May 2016 showed high levels of compliance (range from 93% to 100%). The audits showed there had been increased compliance in completing debrief sessions since August 2015 but further improvements were needed. This was discussed with the theatre teams during safety briefs to aid learning and improve compliance.
- If a patient rang the hospital following surgery, they would be triaged by a nurse, if they needed to return to the hospital a taxi would be provided for them if they did not have access to transport.

## Nursing staffing.

- The ward and theatre areas had a sufficient number of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The ward manager told us they used their own in-house acuity tool to determine the staffing levels needed for appropriate patient care. The theatre staffing levels were based on nationally recognised guidelines such as by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Anaesthetic and Recovery Nurses Association (BARNA).
- All surgical patients were admitted for planned procedures and patient acuity was determined during pre-operative assessment. This allowed the ward and theatre managers to determine the staffing levels needed for patients prior to their admission. Staffing levels were increased if a patient requiring additional support was identified during their pre-operative assessment.
- The staffing levels on the ward consisted of at least two nurses and one healthcare assistant (HCA) during the morning and evening shifts in the inpatient ward and at least two nurses and one HCA in the day case area. There were at least two trained nurses on duty during the nights.

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- The staffing establishment on the ward was 11.6 whole time equivalent (wte) nurses and 2.6 wte HCA's. There was one nurse vacancy and one HCA vacancy at the time of our inspection. The ward manager told us recruitment for these posts was on-going.
- The staffing establishment in the theatres was 6.2 wte nurses and 16.5 wte support staff. There were two members of staff on long-term sick leave and the theatre manager told us they were actively recruiting to cover these posts.
- The hospital used their own team of bank staff made up of existing staff employed by the hospital to provide cover for staff sickness or leave. The proportion of bank or agency staff used across the surgical services averaged 9.7% between April 2015 and March 2016. This was lower (better) when compared with other comparable independent hospitals during this period.
- Records showed the shift fill rate was 100% in the ward and theatre areas between January 2016 and March 2016.
- Nursing staff handovers occurred three times a day and included discussions around patient needs, their medication and their present condition.

## Surgical staffing.

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital.
- The consultants and anaesthetists were responsible for their individual patients during their hospital stay.
- The hospital had arrangements with an external medical agency to provide resident medical officers (RMOs) that worked alternate shifts for two weeks. During their shift, one RMO was based at the hospital 24 hours per day for two weeks. The RMO was resident on site and was available on-call during out-of-hours.
- During their shift, the RMO was responsible for providing medical cover on the ward. Their duties included the monitoring of patients in the ward areas, prescribing medicines, cannulation and taking blood samples if needed.
- The RMO told us they received induction training and were provided with trust policies applicable to their role, such as the policy for patient transfer. They also told us

they received good support from the ward staff and could contact the consultant or anaesthetist responsible for a particular patient if further advice or support was needed.

- Ward staff told us that the RMO cover was sufficient to meet patient needs because the majority of patients were deemed low risk and did not have complex medical needs.

## Major incident awareness and training.

- There was a major incident and business continuity plan that listed key risks that could affect the provision of care and treatment. Guidance for staff in the event of a major incident was available in each of the areas we inspected.
- There was a hospital-wide resuscitation team in place for dealing with medical emergencies. The team was led by the RMO and included a team of nurses and supporting staff that were trained in advanced life support for adults and children.

## Are surgery services effective?

Good 

We rated Effective as 'Good' because: -

## Evidence-based care and treatment

- Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and Royal College of Surgeons guidelines.
- The quality account 2015/16 showed the hospital participated in two national clinical audits between April 2015 and March 2016. These were elective surgery performance reported outcomes measures (PROMs) and the National Joint Registry (NJR). The hospital also participated in 79 local clinical audits during this period.
- Findings from clinical audits were reviewed during routine clinical governance committee meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- Staff in the ward and theatres used enhanced care and recovery pathways, in line with national guidance.
- Staff used integrated care pathways for surgical procedures such as for hip or knee replacement and these were based on national guidelines.

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- Policies and procedures reflected current guidelines and staff told us they were easily accessible via the hospital's intranet.

## Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used a pain assessment score to assess the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort. We were not made aware of any pain relief audits.
- Patients were given an information leaflet to take home which provided information on how to manage pain symptoms following discharge from the hospital.
- Patients told us they received good support from staff and their pain relief medication was given to them as and when needed.

## Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Patient records showed fluid balance charts were in place. A nutrition and hydration audit carried out in December 2015 showed staff compliance was 65%. The audit highlighted discrepancies in the way staff completed the fluid balance charts e.g. no intravenous (IV) fluid totals recorded.
- Further training was provided to staff as part of a clinical training day and a further audit carried out in March 2016 showed compliance had improved to 75%. The quality improvement lead told us further improvement was needed and training and awareness exercises had been undertaken to improve compliance and this would be monitored in future audits.
- Patients with difficulties eating and drinking were placed on special diets. Special meals were also prepared for patients with diabetes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Staff could provide 'halal' or 'kosher' meals if requested.

## Competent staff

- Newly appointed staff underwent an induction process for up to two weeks and their competency was assessed prior to working unsupervised.
- Staff told us they received annual appraisals. The hospital reported that all ward-based staff and 99% of theatre staff had completed their appraisals at the time of our inspection.
- Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital). Practising privileges were reviewed every five years by the hospital's medical advisory committee (MAC). This included a review of appraisals and scope of practice and checks for any reported incidents related to the individual consultant.
- Records showed there were 140 consultants utilised at the hospital under practising privileges and these had been reviewed. There were no consultants in the surgical services with any outstanding queries relating to their practising privileges.
- We spoke with three consultants and they told us they submitted information such as appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks to the hospital on an annual basis.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers. For example, six healthcare assistants in the theatres department had been given the opportunity to train as surgical first assist scrub practitioners (a theatre practitioner assisting the operating surgeon in place of a doctor).

## Patient outcomes

- There had been no patient deaths reported at the hospital between April 2015 and March 2016.
- The hospital participated in national audit programmes such as performance reported outcomes measures (PROMs) and the National Joint Registry. Audit findings were reviewed and monitored at routine clinical governance committee and medical advisory committee meetings.
- The national joint registry (NJR) data showed that hip and knee mortality rates at the hospital were either similar to or better than the national average for the period between April 2003 and July 2015. The data also

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showed that the quality of information submitted by the hospital to the NJR was 'as expected' for two of the three indicators and 'better than expected' for one indicator (consent).

- Performance reported outcomes measures (PROMs) data between April 2014 and March 2015 showed that the percentage of NHS-funded patients with improved outcomes following groin hernia, hip replacement and knee replacement procedures was similar to the England average.
- There had been four unplanned patient readmissions to the hospital within 28 days of discharge between April 2015 and March 2016. The rate of unplanned readmissions was similar to other comparable independent acute hospitals during this period.
- The hospital had started its participation in three local Commissioning for Quality and Innovation (CQUIN) standards during 2016/17. These related to dementia patients communication policy, clinical guidance and quality standards and Advancing Quality (HK2016) for hip and knee replacement. The hospital reported that CQUIN targets for April 2016 to June 2017 (Quarter 1) had been achieved.

## Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the ward and theatres. Staff told us they had a good relationship with consultants and the resident medical officer (RMO).
- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.
- The ward and theatre staff carried out 'safety huddles' on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff so patient care could be coordinated and delivered effectively.

## Seven-day services

- Patients were seen daily by their consultant, including on weekends. The consultant surgeons and anaesthetists provided 24 hour, seven day on-call cover for patients following surgery. The arrangements in place with the hospital were for consultants to be within 30 minute driving distance from the hospital to ensure they could attend patients promptly if needed.

- Where consultants lived further than 30 minutes driving distance or were unavailable due to leave or other commitments, they were required to have cross-cover arrangements with another consultant within the same specialty area and who also held practicing privileges at the hospital.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.
- The ward accommodated overnight patients seven days per week and ward staffing levels were suitably maintained during out-of-hours and weekends. The RMO provided out-of-hours medical cover for the inpatient ward 24 hours a day, seven days per week.
- The physiotherapy services were available on site during the day on weekends. There was an on-call rota for key staff groups, including senior managers, pharmacy, physiotherapy and imaging (such as X-rays). An on-call emergency theatre team was also available out of hours in case a patient needed to return to theatre unexpectedly.

## Access to information

- The hospital used paper based patient records. The patient records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- We saw that information such as audit results, performance information and internal correspondence were displayed in all the areas we inspected.
- Staff could access information such as policies and procedures from the hospital's intranet. Staff told us they could access up to date national best practice guidelines and prescribing formularies when needed.
- The hospital used pre-printed care pathway booklets for individual procedures and these were version-controlled and readily available. These were developed by the provider's corporate clinical governance teams and staff from the hospital had input in the development of care pathways.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek verbal informed consent and written consent before providing care or treatment to patients.

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- The consultants sought consent from patients undergoing surgery during the initial consultation process and again on the day of surgery. Patient records showed that written and verbal consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out a surgical procedure.
- Staff were aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS). Staff received this training alongside the mandatory safeguarding adults training. There were no patients identified during the inspection that had DoLS in place at the hospital.
- Staff told us the majority of admitted patients had the capacity to make their decisions. Patients that lacked capacity were identified during their pre-operative assessment in order to determine whether they could be admitted for treatment at the hospital.
- Where patients lacked the capacity to provide informed consent, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

## Are surgery services caring?

Good 

We rated Caring as 'Good' because: -

### Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. We observed staff providing care and speaking to patients in a respectful manner.
- Staff spoke with patients discreetly to maintain confidentiality. Patients transferred between the ward and theatre areas were given dressing gowns and slippers and their dignity was maintained.
- We spoke with eight patients. All the patients said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them

respect and ensured that their dignity was maintained. The comments received included: "can't fault the staff and facilities, feel well cared for" and "staff are lovely, brilliant care and privacy is respected".

- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The hospital collected test data for all NHS-funded patients that were admitted as inpatients or underwent day surgery.
- The test data between October 2015 and June 2016 showed the surgical services had consistently achieved scores of 100% with response rates between 25% and 96%. This showed that patients were very positive about recommending the hospital to their friends and family. The patient scores and response rates were better than the England average for independent sector NHS patients during this period.
- The hospital also carried out monthly patient satisfaction surveys and the feedback was used to look for improvements to the service. The survey results from July 2015 to June 2016 showed the responses were positive with monthly patient satisfaction scores above ranged between 93.9% and 100%.
- All patients who had surgery at the hospital received a telephone call 48 hrs following surgery to check on their well-being and their pain control.

### Understanding and involvement of patients and those close to them.

- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.
- We observed staff speaking with patients clearly in a way they could understand. Staff were respectful and sought permission from patients before they delivered care or treatment.
- Patients told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. The comments received included: "staff are friendly" and "staff have the time to stop and listen to you".

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- Patients also spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- We were not able to speak with the relatives or carers of patients but the staff and patients we spoke with told us relatives and carers were kept fully involved throughout the patient's stay at the hospital.

## Emotional support

- Patients told us the staff were calm, reassuring and supportive and helped them to relax prior to undergoing surgery. One patient commented that "the anaesthetist was reassuring and helped calm nerves".
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services.

## Are surgery services responsive?

Good 

We rated Responsive as 'Good' because: -

### Service planning and delivery to meet the needs of local people

- Patients had an initial consultation to determine whether they needed surgery. These consultations took place at the hospital and also as outpatient clinics in a number of general practitioner (GP) clinics across a number of areas such as Skelmersdale and Formby to allow patients in those localities easier access to services provided by the hospital.
- The initial consultation was followed by a pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.

- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the hospital. For example, Patients with an American Society of Anaesthesiologists (ASA) physical status score of 4 were excluded. The majority of patients admitted to the hospital had an ASA score of 1 or 2 i.e. patients that were generally healthy or suffered from mild systemic disease.
- NHS funded patients requiring emergency surgical procedures, transplant surgery, treatment of malignant diseases and any procedures that were likely to require critical care were excluded from undergoing treatment at the hospital.
- The ward area had 23 inpatient beds on the first floor with an additional six mixed use (day case or inpatient) rooms on the ground floor. There were two operating theatres (including one with laminar flow) and a treatment room that was used for endoscopy procedures.
- The theatres operated from 8.30am to 8pm during weekdays and 8am to 1pm on Saturdays. The endoscopy theatre sessions ran from 8am until 5.30pm and also for a limited number of hours on Saturdays.
- There was sufficient capacity to provide care and treatment for patients undergoing surgery at the hospital. Planning and scheduling meetings took place at least weekly to monitor staffing and capacity issues so that patients could be managed and treated in a timely manner.

### Access and flow

- There were 697 inpatient attendances and 5,394 day case attendances at the hospital between April 2015 and March 2016. Approximately 89% of surgical patients attending the hospital underwent day surgery.
- The majority of patients (86%) were NHS funded patients and the remaining 14% were privately funded. The hospital reported that 11% of all NHS patients and 17% of all other funded patients stayed overnight at the hospital between April 2015 and March 2016.
- The majority of patients were referred to the hospital by their general practitioner (GP) via the NHS 'choose and book' system.



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- The inspection did not highlight any concerns relating to the admission, transfer or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements. Two patients told us they chose to be treated at the hospital because of the lower waiting times.
- Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.
- Patient records showed staff had completed a discharge checklist that covered areas such as medication and communication to the patient and other healthcare professionals, such as GPs, to ensure patients were discharged in a planned and organised manner.
- The hospital reported that there were 3,297 admissions for surgery over the past six months. There had been 40 operations cancelled on the day of surgery during this period. This showed that a relatively small proportion of operations (1.2%) were cancelled at the hospital. Where operations were cancelled, patients were treated within 28 days of their cancellation.
- The main reasons for cancellations on the day of surgery were due to equipment failure in endoscopy and ophthalmology. The theatre manager told us they managed the risk to patients by using equipment and facilities at the provider's other local hospitals and by liaising with the equipment manufacturers to resolve equipment issues promptly.
- The hospital reported that 100% of admitted NHS patients began treatment within 18 weeks of referral for each month between April 2015 and March 2016. A weekly 'elective wait monitoring report' was reviewed by staff to identify patients approaching the 18 week wait period and these patients were prioritised so they could begin treatment prior to breaching the 18 week wait time target.
- Staff could access a language interpreter if needed.
- The hospital did not provide any day case or inpatient surgical services for patients aged under 18 years.
- As part of the pre-operative assessment process, NHS funded patients with certain conditions were excluded from undergoing treatment at the hospital. For example, patients living with dementia
- The pre-operative assessment nurse told us the majority of patients admitted for treatment had the capacity to make their own decisions. The pre-operative assessment process identified NHS and privately funded patients living with dementia or learning disabilities and this allowed the staff to decide whether they could accommodate these patients or refer them elsewhere.
- If patients needed to urgently return to the hospital following surgery, a taxi would be provided to bring them into the hospital for review.
- There was a trained dementia champion and dementia link nurses in the ward and theatre areas. The practice development manager told us the hospital had recently commenced dementia training for all staff and this training was on-going over the next few months.
- The dementia training also included the use of tools to aid staff when providing care for patients living with dementia; including a 'This is me' document that was designed to be completed by the patient or their representatives to include key information such as the patient's likes and dislikes

## Learning from complaints and concerns

- Information on how to raise complaints was visibly displayed in the areas we inspected.
- In the period of April 2015 to March 2016 the hospital had received 14 complaints, which were about surgical services. This figure was lower than the previous two years.
- Patients told us they did not have any concerns but would speak with the staff if they wished to raise a complaint. Staff understood the process for receiving and handling complaints.

## Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.

# Surgery

- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints.
- Where the complaint investigation had not been completed within 20 working days, staff were required to send a holding letter explaining why a response had not been sent, followed by further holding letters every 20 days until the complaint was resolved.
- Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns with the Parliamentary and Health Service Ombudsman for NHS funded patients or the Independent Sector Complaints Adjudication Service (ISCAS) for privately funded patients.
- The hospital received 14 written complaints between April 2015 and March 2016 relating to the surgical services. The most frequent reasons for complaints were patients unhappy with the care they received or complaints about fees (private funded patients).
- Hospital records showed the complaints had been resolved within the hospital's 20-day target. None of the complaints had been referred to the Ombudsman or ISCAS.
- Staff told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes we looked at.
- The hospital's 'Northern Blitz Spirit' strategy for 2016/17 outlined the overall growth strategy for the hospital and was based on governance, growth, cost control, marketing intelligence and operational detail.
- There was no specific documented strategy for the surgical services. However; the ward and theatre managers had outlined key objectives for their departments and these were based on the 'Ramsay way' values and the 'Northern Blitz Spirit' strategy.
- Information relating to the 'Ramsay way' values and the 'Northern Blitz Spirit' strategy were clearly displayed in the ward and theatre areas. This had been cascaded to staff across the surgical services and staff had a good understanding of these.

## Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place with committees for medicines management, infection control and health and safety feeding into the clinical governance committee and medical advisory committee (MAC).
- There was a corporate risk register and risk registers for each clinical area. Risk management was an agenda item on the health and safety committee however as the MAC chair did not sit on the health and safety committee there was no clear clinical ownership of risk.
- The ward and theatre managers logged identified risks on local departmental risk registers and we saw that the local risk registers were up to date and reviewed on a regular basis. Key risks were placed on the hospital-wide corporate risk register.
- Routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. The quality improvement lead coordinated most of the audit activity and maintained the hospital's audit schedule.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- The hospital was completing the workforce race equality standard (WRES) reporting template.

## Are surgery services well-led?

Good 

We rated Well-led as 'Good' because: -

### Vision and strategy for this this core service

- The corporate provider's 'Ramsay way' was based on six values relating to being caring and progressive, taking pride in achievements, recognising and encouraging staff, building constructive relationships and maintaining a sustainable and profitable organisation.

### Leadership / culture of service related to this core service






# Surgery

- The overall lead for the surgical services at the hospital was the matron. The ward and day case areas were led by a ward manager. The theatre manager was responsible for the day to day management of the theatres. Both managers were established and had been in post longer than 12 months.
- All the staff we spoke with were highly motivated and positive about their work and described the managers as approachable, visible and provided them with good support. Staff told us there was a friendly and open culture.
- The overall staff sickness rates between April 2015 and March 2016 were 4% for ward staff and 1.3% for theatres staff. The sickness rate for the ward staff was slightly higher than other comparable independent hospitals during this period. However, we saw that staffing levels were suitably maintained through the use of bank and agency staff.
- The overall staff turnover rate for staff across the surgical services was 9.7% during this period. This was lower than other comparable independent hospitals during this period.
- The surgical services also engaged with the public through ad hoc focus groups, such as the endoscopy user group.
- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings across the ward and theatre areas. Staff spoke positively about the visibility and level of engagement they received from the hospital's senior management team.
- Staff participated in the hospital's annual 'my voice' staff survey, which sought feedback from staff on areas such as work environment, patient focus, health and well-being, communication and leadership. Results from the 2016 survey showed staff feedback was very positive and the hospital scored better than the provider's other hospitals.
- The findings from the survey were shared with staff in April 2016 as well as further actions to improve in areas such as communication and leadership.

## Public and staff engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
  - This was done formally through participation in the NHS Friends and Family test and by conducting monthly patient feedback surveys. Feedback from these surveys showed patients were very positive about using the hospital.
- ## Innovation, improvement and sustainability
- The surgical services were in the process of submitting a business case for the development of a second laminar flow theatre and a minor operations theatre that would increase capacity within the department.
  - The hospital planned to install new equipment within the endoscopy unit and to introduce an electronic patient record system over the next year.
  - All the staff we spoke with were confident about the sustainability of the surgical services. They felt there was a stable workforce that worked well together and provided a good standard of care and treatment.

# Outpatients and diagnostic imaging

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

## Are outpatients and diagnostic imaging services safe?

Good 

We rated this service as good, because:-

### Incidents

- The outpatient and diagnostic imaging department (OPD) had 12 clinical incidents between April 2015 and March 2016. This was less than 0.1 per 100 outpatient attendances (and was lower than other independent hospitals we held data for). There were no diagnostic imaging incidents that required reporting to the regulator in this period.
- There were two non-clinical incidents in the OPD during the same period. This was a rate of less than 0.2 per 100 outpatient attendances (this was again lower than other independent hospitals).
- The hospital had an incident reporting policy in place. This provided definitions of incidents, including near misses and never events, and set out staff responsibilities to report incidents on the hospital's incident recording system within the same shift period. Departmental and corporate managers reviewed incident reports, instigated investigations, put in place corrective actions if necessary, and escalated any risks to senior management. Any incidents with a severity rating of one or two instigated a root cause analysis investigation.

- All clinical, non-clinical, and administrative staff we spoke with were aware of the incident reporting system, and understood their responsibility to report incidents.
- Due to the nature of outpatient consultations and limited treatment, there were no specific safety goals set by the department. However, we were assured that safety of patients was paramount for staff. The head of department told us the department's aim was to ensure 100% safety for all their patients.
- Although there were no serious incidents relating to the outpatient and imaging departments, the hospital had processes in place to carry out root cause analysis of any serious incidents that occurred. This included seeking the views of staff involved in incidents. Analysis used the national patient safety agency 'root cause analysis toolkit' and the 'five whys' technique to analyse the information and to identify the root cause of each incident.
- Lessons from incidents and complaints were shared in a number of ways. Incidents were discussed in local management and heads of department meetings, and regionally in the northern matrons' committee meetings. Staff had access to lessons learnt from incidents and complaints via the hospital's computer system, and a hard copy of these was held within the outpatients' nurses' station.
- There were no patient deaths related to care and treatment received in the department. As such, the department was not involved in mortality or morbidity reviews.

# Outpatients and diagnostic imaging

- The Ionising Radiation Regulations 1999 (IRR99) requires employers to keep employee exposure to ionising radiations as low as reasonably practicable, and to ensure that exposures must not exceed specified dose limits.
  - The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. The current rules were issued in March 2015 and we saw copies for 2013 and 2014. The rules were supported by the hospital's incidents greater than intended exposure of patients caused by procedural error policy. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor (RPS), who in turn logged the incident on the hospital's incident reporting system. The incident was then reported directly to the group's radiation protection advisers for dose calculation, and where necessary to the medical physics expert. The rules and policy also set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive.
  - Senior staff were aware of the duty of candour requirements. Operational staff were less aware of the legislative requirements of the duty of candour; however, staff we spoke with were aware of the principles of the duty of being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
  - Although there were no incidents of moderate or severe harm related specifically to the radiology department, staff told us they were asked to provide input into an investigation of a never event in theatre which triggered the duty of candour.
- Cleanliness, infection control and hygiene.**
- Cleanliness, infection control and hygiene standards were maintained in the OPD.
  - Outpatients, physiotherapy and diagnostic imaging, were visibly tidy and clean with hand gel sanitisers at the entrance of each area. Sanitisers, hand washing facilities and sterile wipes were available in each treatment room. Personal protection apron dispensers were available throughout the department. We saw staff following the 'bare below the elbow' requirement of the policy. Cleaning was carried out by housekeeping staff and cleaning rotas were in place.
  - The hospital had a hand hygiene policy in place. The policy was supported by a quarterly observational hand hygiene audit by the infection control link nurse. The policy took into account the hand decontamination guidelines from infection control nurses association, and clean hands saves lives from the national patient safety agency.
  - The hospital's hand hygiene audit for July 2015 showed 100% compliance with the requirements of the hospital's policy. This dipped to 88% in October as staff had not used elbows to switch off running taps; a hand hygiene poster was missing; and patients and visitors had not been given the Ramsay Health Care UK hand hygiene leaflet. However, the result increased to 96% in December with only the leaflet being missed, and by April 2016 it had further increased to 99% (again with the leaflet affecting the result).
  - The audit results indicated that the hospital complied with the National Institute for Health and Care Excellence (NICE) Quality Standard 61 Statement 3: People receive healthcare from healthcare workers who decontaminated their hands immediately before and after every episode of direct contact or care. However, although staff initials were used to identify those who carried out the audit and those who were observed, there was no indication in the audit results of which areas or departments the audits covered. This meant there was a risk that poor trends in one particular area may not be easily identified.
  - In addition, an infection prevention and control environmental audit was carried out each quarter. The results indicated varied compliance between August 2015 and May 2016 (the lowest average compliance rate was 88% with the highest compliance 99%). However, the audit results were not always clear about which areas of the hospital the result related to, and did not always detail the corrective actions to be taken. This meant there was an increased risk that infections from environmental issues may not be mitigated.

# Outpatients and diagnostic imaging

- The hospital had a standard infection control precautions policy in place, which covered areas including: hand hygiene; use of personal protection equipment; safe use and disposal of sharps; and maintaining a clean environment.
- Infection prevention and control meetings were held every three months, which were supported by quality regional meetings. The meetings included standing items for review of infection incidents in the previous quarter; the outcome of any relevant audits that had been carried out; issues arising from cleaning the environment; general buildings facilities infection control issues; and a review of any relevant updated guidelines and policies.
- A cleaning schedule and log was in place in the radiology department. Staff cleaned clinical equipment after each patient. Non-clinical areas were cleaned by the housekeeping team.
- The hospital had a screening policy for patients who had MRSA (methicillin-resistant staphylococcus aureus). All patients due to receive treatment in the outpatient's department were screened for MRSA. Patients were swabbed and any MRSA positive screening results were notified to the patient's GP. Patients were invited in for eradication therapy and were rescreened before treatment was commenced.
- Within the radiology department patients with MRSA or other suspected communicable infections were allocated appointments at the end of the clinic. If this was not possible, the room would be vacated for 30 minutes after cleaning. Staff also had access to specialist theatre cleaning equipment if needed.
- The hospital carried out decontamination of treatment areas before clinics started. The outpatients department were compliant with the Department of Health's technical memorandum on decontamination of flexible endoscopic scopes, and were no longer using rigid scopes. The remainder of equipment used was disposable.
- The outpatients department was located on the ground floor. The open plan waiting area for NHS patients was in the reception area. A separate enclosed waiting room for private patients included coffee making facilities. Both areas were bright, clean, and tidy with comfortable seating.
- There were nine outpatient consultation rooms, which included specialist ear, nose and throat, and eye rooms, a soundproofed audiology room, and a room designated for pre-operative assessments. A number of treatment rooms had trolleys of sterile disposable equipment. We checked a range of equipment held in these; equipment was sealed and within date.
- A resuscitation trolley including an automated defibrillator was available and easily accessible. Daily and monthly checks were carried out of the equipment held on the trolley.
- The diagnostic imaging and physiotherapy departments were also on the ground floor of the hospital and shared a common waiting area. The radiology department carried out on-site plain X-rays, dental X-rays, fluoroscopy, ultrasound scanning, urodynamic testing, and outpatient injection procedures. A mobile X-ray machine was available for obtaining images of patients on the ward in emergencies, and an image intensifier was available in theatre for endoscopy procedures.
- The physiotherapy department, which also supported orthopaedic inpatients, included two individual treatment rooms and a small rehabilitation area including gym equipment. The rehabilitation area could accommodate up to three patients at a time, with privacy curtains between bays. However, staff were concerned that the physical size of the department was small which had led to some patient concerns about privacy.
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## Environment and equipment

- The design, maintenance, and use of the facilities and equipment within the department kept people who used the hospital's services safe.

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- We reviewed a range of equipment in use within the treatment rooms. Green stickers were in place to identify that equipment had been cleaned and was ready for use. All portable electrical equipment we reviewed had been appropriately tested and labelled with the date when testing would be next required. The hospital's maintenance team held a log of tested equipment.
- Detailed risk assessments were in place for each piece of radiation equipment within the department. These included assessment of risks to staff and patients, staff training in the use of each piece of equipment, signage to ensure mitigation of risks (for example door to be closed), and action plans for maintenance and repair.
- Staff in the department told us they rarely had any issues with faulty equipment, and no clinics were impacted or cancelled because of faulty equipment.
- The diagnostic imaging department had clear signage in place, which included working hazard warning signs outside each area when equipment was being used. The hospital had common policies and procedures in place that set out details of departmental staff responsibilities shared with staff of the mobile magnetic resonance imaging (MRI) and computerised tomography (CT) scanning provider. These included the MRI safety policy, medical emergencies in scanner policy, and medical emergency/arrest on mobile scanner policy.
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- Visual and detailed checks of PPE equipment such as lead aprons were carried out, and results were logged. PPE equipment was regularly deep cleaned, and X-ray checks of the PPE equipment was carried out to determine if there were any breaks in the protective material that would lead to inadvertent exposure. PPE equipment checks were included in the department's audit against the Ionising Radiation Medical Exposure Regulations 2000 [IR(ME)R] and IRR99 regulations. The audit results in February 2016 indicated full compliance by the department.
- The health and safety audit achieved 91% compliance on workplace administration safety; 100% on occupational health and general workplace safety; 96% on plant and equipment; 100% on medical gases and equipment; 100% on COSHH, electrical safety, office areas, manual handling, and first aid; 95% on fire safety and evacuation; 100% on waste disposal, water services, ventilation, decontamination, mechanical, building fabric and systems and management of contractors.
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- NHS prescription forms, used by consultants, were securely stored in a locked cupboard.
- The radiology department did not hold any controlled medicines; however, there were limited medicines in use in the department as prescribed by the doctor referring the patient. These were stored in a locked cupboard within the X-ray room with maximum/minimum thermometers in place and relevant

# Outpatients and diagnostic imaging

temperature readings recorded. We checked a range of medicines within the cupboard. All medicines were in date and any opened bottles had the date of opening clearly recorded. Oxygen was appropriately stored.

- A service level agreement (SLA) was in place with the pharmacy service of a local acute hospital trust. As part of this, a pharmacist visited the hospital each week to review the storage of medicines. The pharmacists were also available by telephone for advice if needed. A medicines audit was carried out as part of this agreement every month.

## Records

- There were systems and processes in place in the department to ensure the management of people's records were accurate, complete, legible, up to date and stored securely.
- The hospital had ISO20071 information security accreditation and was audited on compliance against this. The hospital had current action plans in place to address minor non-compliance issues that had been highlighted in the 2016 audit.
- The hospital had a medical records management policy in place, which took into account the requirements of the data protection act 1998, and the access to health records act 1990. This set out responsibilities for all staff members in the creation, handling, storage and destruction of records. It also detailed standards for confidentiality and set out rights to access records. The policy was supported by a Caldicott guardian policy, based on the seven Caldicott principles.
- Any incidents relating to information security were recorded on the hospitals incident reporting system. Information incidents were reviewed by the corporate information governance committee and were monitored by the information governance manager.
- We reviewed five patient care records within the outpatients department. All were of good quality. Referrals, relevant history, patient consent, plans of care, decisions and, where appropriate, discharge summaries were all clearly recorded.
- There was a clear and robust process in place for the storage and movement of records within the department. Records needed for each clinic were transferred to the department from medical records in the morning and afternoon. Whilst within the department, records were securely stored. The hospital did not permit records to be taken off-site, and all staff including consultants were aware of this policy. This meant that all records, including those created by consultants with practicing privileges, remained securely on site.
- The hospital reported that only one per cent of records were not available for clinic appointments. Staff told us that, in this situation, they printed any electronic letters held and placed into a temporary record for the consultant to use in clinic. Temporary records were subsequently destroyed.
- The hospital was in the process of introducing an electronic patient record system; however, this was still in the process of being implemented at the time of our inspection.
- The diagnostic imaging department held records within the PACS (picture archiving and communication system) electronic system. Referring consultants also had access to this system which meant that copies of the images and the radiology reports were directly available to consultants. The department had a procedure in place for requesting access to patient images held by other healthcare organisations through the PACS image exchange portal system if needed.
- A medical records audit programme was in place which carried out checks every month. This showed a compliance rate of between 89% and 97% (with one outlier at 65%) between July 2015 and April 2016. The audits included actions taken to improve, the responsible person, and date for completion. However, the results do not clearly indicate which department the audit related to.
- We reviewed two patient records for the physiotherapy department's acupuncture clinic. Both included appropriate and clear information, including referrals, a brief pain inventory and visual score assessment, and completed consent forms.
- A process was in place for clinics where notes were not available to the consultant. There were no reported clinic cancellations within the department because of records not being available.



# Outpatients and diagnostic imaging

- When transported off site, patient records were kept in lockable cases.

## Safeguarding

- The hospital had safeguarding systems and processes in place to ensure that people were kept safe. Staff received safeguarding training, and knew how they could obtain further advice.
- The hospital had a safeguarding adults at risk of abuse or neglect policy, which was based on a number of guidelines from professional bodies and the Department of Health.
- The policy covered a range of safeguarding issues including domestic abuse and female genital mutilation (FGM). Flowchart pathways were provided to guide staff on the appropriate response to safeguarding or FGM concerns. Copies of the flowcharts were clearly displayed within the nursing office.
- The hospital had a number of on-site adult safeguarding leads, who included the matron, the medical advisory committee chairperson, the ward manager, the quality improvement lead, the ward sister, and the outpatients' team leader. The hospital's safeguarding leads had received safeguarding level three training in safeguarding children and young people; all clinical staff had level two training, and all non-clinical staff had level one training. All staff had also received training in safeguarding of vulnerable adults. This meant that staff were able to recognise and report, or obtain additional advice, if they identified a potential safeguarding concern.
- Although a decision was made to stop treating children at the hospital in December 2015, staff recognised the need to maintain level three safeguarding training as children often accompanied adult patients.
- Clinical, non-clinical and administration staff were all aware of the types of issues that may need to be reported as a safeguarding concern or alert. Staff were aware of the process to follow to obtain advice from the leads, or to raise a safeguarding concern or alert via the hospital's incident reporting system. Posters providing information relating to safeguarding were displayed in staff areas.

## Mandatory training

- The hospital had a mandatory training policy. This was supported by a mandatory training matrix. Training was delivered through e-learning packages for: data protection; emergency management: fire and personal safety; equality, human rights & workplace diversity; health and safety; prevention of infection; information security; manual handling; non-clinical basic life support; clinical basic life support; and child protection. The policy set out employee's responsibility to ensure mandatory training was completed each year and detailed sanctions that would imply for non-completion, including potential disciplinary action.
- A tracker was used in conjunction with the training matrix to ensure that staff completed mandatory training. This highlighted when modules were due for renewal.
- Mandatory training completion was high for staff in the department, with only two staff that had yet to complete dementia training.
- All staff, including bank and agency staff, completed an induction training programme.

## Assessing and responding to patient risk

- The department had a resuscitation trolley available for use in emergencies. A dedicated internal telephone was in place for alerting staff to emergencies. This was also provided to staff of the other healthcare provider who operated the mobile computerised tomography (CT) and magnetic resonance imaging (MR) scanners.
- Risk assessments, including control of substances hazardous to health (COSHH) risk assessments, were in place for equipment and chemicals in use within the outpatients department. We reviewed a number of these which were detailed and up to date.
- The hospital had two radiation protection supervisors. The supervisors were supported by Ramsay Health Care UK radiation protection advisers, who were based in St Georges Hospital in London. The advisers were available on call to provide advice.
- A radiation protection adviser audit was carried out every year. The most recent audit made five recommendations; all of which had been implemented and the hospital had taken appropriate action to address shortfalls.

# Outpatients and diagnostic imaging

- In line with the IR(ME)R regulations, and the hospital's policy, a training record was kept for all non-medical referrers' scope of practice and entitlement to refer for imaging. Ten physiotherapists in the hospital had entitlement to refer patients for imaging.
- All staff had recently signed to confirm they had received up to date training and knowledge in line with the regulations. Although two entries for bank radiographer staff had yet to be signed, this was because the individuals involved had not been on duty since. The service lead told us these bank staff would be asked to sign when they were next on duty.
- Clear, illuminated, "radiation in use" warning signs were in place by doors leading into any area where radiation equipment was used.
- The hospital had an examination of females of child bearing age policy, which included a pathway flowchart for staff to follow. However, staff in the radiology department told us that they do not carry out X-rays or scans on pregnant women. Warnings signs asking patients to tell staff if they may be pregnant were clearly displayed on doors into radiation controlled areas.
- A clinical radiology contrast agent and medicines for diagnostic imaging policy was in place. This included a treatment pathway that was based on the Royal College of Radiologists guidelines on the use of contrast agents (dyes used in radiology to improve the visibility of internal bodily structures). Blood tests were carried out on patients at risk of acute kidney injury, such as those with patients with diabetes. Where the test results were abnormal, the radiologist decided on what action to take.
- Diagnostic imaging staff provided two examples of where issues of risk had been addressed. The first related to an increased number of requests for mobile X-rays to be carried out on the in-patient ward when the patients were not in a critical or urgent condition. This meant that there was an increased risk of radiation exposure to other patients, and increased environment radiation levels. This was raised as a radiation protection issue with the matron and a standard operating procedure with strict criteria was put in place. Staff told us that the number of mobile X-ray requests had since reduced dramatically.
- The second example related to patients who were discharged by consultants before they had received post-operative X-rays. A reminder about this was sent to the consultant, which also drew on the hospital's values 'The Ramsay Way'.
- The diagnostic imaging department had an unexpected findings / significant pathology policy. This meant abnormal findings during imaging were appropriately highlighted to the radiologist, who discussed these with the patient. If transfer to an acute NHS hospital was indicated, this was arranged.
- The diagnostic imaging department had experienced two such cases recently where staff arranged immediate emergency transfer to hospital in line with the policy.

## Nursing staffing

- Staffing levels were planned and reviewed using an electronic rostering management system which embedded indicators for safety and effectiveness. This enabled heads of departments to manage rotas, shift allocations, annual leave and sick absences, skill mix and staff requirements including senior cover. The system provided indicators of safety and effectiveness and allowed heads of departments to manage shift allocation, annual leave and sickness absence.
- Staffing levels were planned a week in advance and reviewed on a daily basis and again at shift changeover to enable flexibility between the needs of patients and any unforeseen issues that arose. Staffing rotas within the outpatients department were planned based on a ratio of six nurses to four healthcare assistants.
- From 1 April 2016, the outpatients department had 4.6 full-time equivalent registered nursing staff, and 2.8 full time equivalent health care assistants. Use of registered bank nurses and healthcare assistants varied. Between April 2015 to March 2016, this increased from 2% to 16%. This was comparable to other independent hospitals.
- Four per cent of outpatient healthcare assistants left the service between April 2015 and March 2016; however, during the same period, no nursing staff left. This was lower than other independent hospitals. During our visit the hospital was advertising for one health care assistant post, and was expecting to advertise for a registered nurse position in the near future.

# Outpatients and diagnostic imaging

- There were no days lost in the outpatient department to nursing staff sickness during the period April 2015 to March 2016, and there were no unfilled shifts in the first three months of 2016. The sickness rate was lower than other independent hospitals where data is held.
- The hospital had an induction policy, which was supported by an induction booklet and checklist. The policy set out the responsibilities of all relevant staff members, including the new employee. New starters met with their line manager to review performance against the induction programme at frequent intervals in line with the policy.

## Medical staffing

- From 1 April 2016, the hospital had 140 doctors and dentists who were directly employed or were practicing under rules of privilege for more than six months. Of these, one radiologist had practicing privileges removed in 2015/2016 following an extensive period of suspension and sickness from their NHS employer. The radiologist had been invited to re-apply for practicing privileges.
  - The hospital had one resident medical officer (RMO – this is a doctor who resides at the hospital and is generally on call 24 hours per day seven days per week), who was employed by a third party organisation. A pre-employment training file was provided to the hospital before each RMO arrived, for review and sign-off by matron. This included clinical training, and standard training including advance life support (ALS), European paediatric life support (EPLS), NHS better blood transfusion, infection prevention and control, the mental capacity act and deprivation of liberty safeguards, equality and diversity, child protection (level 3), safeguarding vulnerable adults effective teamwork; data protection, manual handling and fire safety.
  - The hospital indicated the RMO usually worked on a ward floor for a maximum of eight to nine hours per 24 hour shift on duty and not receive more than five night calls in a seven day period. There was an escalation process in place to obtain standby relief for a 24 hour rest break, if there was a significant increase in the workload. Whenever possible a doctor who was experienced with the hospital was utilised for 24 hour relief cover.
- The diagnostic imaging department employed six radiography staff, working a range of hours including full and part-time. There was a small bank of radiographers available to cover unfilled shifts. All bank staff were experienced within the department and had received up-to-date training, risk assessments and were within their documented scope of practice.
  - The department had six radiologists, five of whom also worked at a local acute NHS hospital. The radiologists also worked locally at other Ramsay Health Care UK hospitals in the area. They provided on-site cover, but were also able to work remotely from other sites and were available on call for advice. A 'radiologist of the week' service was in place for emergencies and where urgent diagnostic intervention was required.
  - The physiotherapy department had 20 staff in total; five of these were contracted by the hospital and the remainder were bank staff. Staff worked flexibly to meet the needs of the department, which included a voluntary weekend rota.

## Major incident awareness and training

- The hospital had a business continuity management policy. Contingency plans were also in place for unexpected events. Staff told us of an example where the radiology department had flooded. This meant that equipment had to be lifted off the floor and subsequently retested.
- Staff had received emergency fire training, and told us that the procedures for this were tested through simulation scenarios. Staff were aware of their responsibilities during a major incident.
- Generators were available if there was a power failure. These were maintained by the hospital's facilities team. Due to the hospital's rural location, staff told us the generators were tested and used regularly.

The hospital was included in regional major incident plans. In the event of a major incident, the hospital's facilities would be used to accept transfers of low acuity patients from other local NHS hospitals. This meant capacity in NHS hospitals could be increased to accept emergency patients.

## Incidents

- The outpatient and diagnostic imaging department (OPD) had 12 clinical incidents between April 2015 and

## Allied healthcare professionals staffing

# Outpatients and diagnostic imaging

March 2016. This was less than 0.1 per 100 outpatient attendances (and was lower than other independent hospitals we held data for). There were no diagnostic imaging incidents that required reporting to the regulator in this period.

- There were two non-clinical incidents in the OPD during the same period. This was a rate of less than 0.2 per 100 outpatient attendances (this was again lower than other independent hospitals).
- The hospital had an incident reporting policy in place. This provided definitions of incidents, including near misses and never events, and set out staff responsibilities to report incidents on the hospital's incident recording system within the same shift period. Departmental and corporate managers reviewed incident reports, instigated investigations, put in place corrective actions if necessary, and escalated any risks to senior management. Any incidents with a severity rating of one or two instigated a root cause analysis investigation.
- All clinical, non-clinical, and administrative staff we spoke with were aware of the incident reporting system, and understood their responsibility to report incidents.
- Due to the nature of outpatient consultations and limited treatment, there were no specific safety goals set by the department. However, we were assured that safety of patients was paramount for staff. The head of department told us the departments aim was to ensure 100% safety for all their patients.
- Although there were no serious incidents relating to the outpatient and imaging departments, the hospital had processes in place to carry out root cause analysis of any serious incidents that occurred. This included seeking the views of staff involved in incidents. Analysis used the national patient safety agency 'root cause analysis toolkit' and the 'five whys' technique to analyse the information and to identify the root cause of each incident.
- Lessons from incidents and complaints were shared in a number of ways. Incidents were discussed in local management and heads of department meetings, and regionally in the northern matrons' committee meetings. Staff had access to lessons learnt from incidents and complaints via the hospitals computer system, and a hard copy of these was held within the outpatients' nurses' station.
- There were no patient deaths related to care and treatment received in the department. As such, the department was not involved in mortality or morbidity reviews.
- The Ionising Radiation Regulations 1999 (IRR99) requires employers to keep employee exposure to ionising radiations as low as reasonably practicable, and to ensure that exposures must not exceed specified dose limits.
- The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. The current rules were issued in March 2015 and we saw copies for 2013 and 2014. The rules were supported by the hospital's incidents greater than intended exposure of patients caused by procedural error policy. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor (RPS), who in turn logged the incident on the hospital's incident reporting system. The incident was then reported directly to the group's radiation protection advisers for dose calculation, and where necessary to the medical physics expert. The rules and policy also set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive.
- Senior staff were aware of the duty of candour requirements. Operational staff were less aware of the legislative requirements of the duty of candour; however, staff we spoke with were aware of the principles of the duty of being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Although there were no incidents of moderate or severe harm related specifically to the radiology department, staff told us they were asked to provide input into an investigation of a never event in theatre which triggered the duty of candour.

# Outpatients and diagnostic imaging

## Cleanliness, infection control and hygiene.

- Cleanliness, infection control and hygiene standards were maintained in the OPD.
- Outpatients, physiotherapy and diagnostic imaging, were visibly tidy and clean with hand gel sanitisers at the entrance of each area. Sanitisers, hand washing facilities and sterile wipes were available in each treatment room. Personal protection apron dispensers were available throughout the department. We saw staff following the 'bare below the elbow' requirement of the policy. Cleaning was carried out by housekeeping staff and cleaning rotas were in place.
- The hospital had a hand hygiene policy in place. The policy was supported by a quarterly observational hand hygiene audit by the infection control link nurse. The policy took into account the hand decontamination guidelines from infection control nurses association, and clean hands saves lives from the national patient safety agency.
- The hospital's hand hygiene audit for July 2015 showed 100% compliance with the requirements of the hospital's policy. This dipped to 88% in October as staff had not used elbows to switch off running taps; a hand hygiene poster was missing; and patients and visitors had not been given the Ramsay Health Care UK hand hygiene leaflet. However, the result increased to 96% in December with only the leaflet being missed, and by April 2016 it had further increased to 99% (again with the leaflet affecting the result).
- The audit results indicated that the hospital complied with the National Institute for Health and Care Excellence (NICE) Quality Standard 61 Statement 3: People receive healthcare from healthcare workers who decontaminated their hands immediately before and after every episode of direct contact or care. However, although staff initials were used to identify those who carried out the audit and those who were observed, there was no indication in the audit results of which areas or departments the audits covered. This meant there was a risk that poor trends in one particular area may not be easily identified.
- In addition, an infection prevention and control environmental audit was carried out each quarter. The results indicated varied compliance between August 2015 and May 2016 (the lowest average compliance rate was 88% with the highest compliance 99%). However, the audit results were not always clear about which areas of the hospital the result related to, and did not always detail the corrective actions to be taken. This meant there was an increased risk that infections from environmental issues may not be mitigated.
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transferred to the department from medical records in the morning and afternoon. Whilst within the department, records were securely stored. The hospital did not permit records to be taken off-site, and all staff including consultants were aware of this policy. This meant that all records, including those created by consultants with practicing privileges, remained securely on site.

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## Assessing and responding to patient risk

- The department had a resuscitation trolley available for use in emergencies. A dedicated internal telephone was in place for alerting staff to emergencies. This was also provided to staff of the other healthcare provider who operated the mobile computerised tomography (CT) and magnetic resonance imaging (MR) scanners.
- Risk assessments, including control of substances hazardous to health (COSHH) risk assessments, were in place for equipment and chemicals in use within the outpatients department. We reviewed a number of these which were detailed and up to date.
- The hospital had two radiation protection supervisors. The supervisors were supported by Ramsay Health Care UK radiation protection advisers, who were based in St Georges Hospital in London. The advisers were available on call to provide advice.
- A radiation protection adviser audit was carried out every year. The most recent audit made five recommendations; all of which had been implemented and the hospital had taken appropriate action to address shortfalls.
- A clinical radiology contrast agent and medicines for diagnostic imaging policy was in place. This included a treatment pathway that was based on the Royal College of Radiologists guidelines on the use of contrast agents (dyes used in radiology to improve the visibility of internal bodily structures). Blood tests were carried out on patients at risk of acute kidney injury, such as those with patients with diabetes. Where the test results were abnormal, the radiologist decided on what action to take.
- Diagnostic imaging staff provided two examples of where issues of risk had been addressed. The first related to an increased number of requests for mobile X-rays to be carried out on the in-patient ward when the patients were not in a critical or urgent condition. This meant that there was an increased risk of radiation exposure to other patients, and increased environment radiation levels. This was raised as a radiation protection issue with the matron and a standard operating procedure with strict criteria was put in place. Staff told us that the number of mobile X-ray requests had since reduced dramatically.

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- The second example related to patients who were discharged by consultants before they had received post-operative X-rays. A reminder about this was sent to the consultant, which also drew on the hospital's values 'The Ramsay Way'.
- The diagnostic imaging department had an unexpected findings / significant pathology policy. This meant abnormal findings during imaging were appropriately highlighted to the radiologist, who discussed these with the patient. If transfer to an acute NHS hospital was indicated, this was arranged.
- The diagnostic imaging department had experienced two such cases recently where staff arranged immediate emergency transfer to hospital in line with the policy.
- There were no days lost in the outpatient department to nursing staff sickness during the period April 2015 to March 2016, and there were no unfilled shifts in the first three months of 2016. The sickness rate was lower than other independent hospitals where data is held.
- The hospital had an induction policy, which was supported by an induction booklet and checklist. The policy set out the responsibilities of all relevant staff members, including the new employee. New starters met with their line manager to review performance against the induction programme at frequent intervals in line with the policy.

## Nursing staffing

- Staffing levels were planned and reviewed using an electronic rostering management system which embedded indicators for safety and effectiveness. This enabled heads of departments to manage rotas, shift allocations, annual leave and sick absences, skill mix and staff requirements including senior cover. The system provided indicators of safety and effectiveness and allowed heads of departments to manage shift allocation, annual leave and sickness absence.
- Staffing levels were planned a week in advance and reviewed on a daily basis and again at shift changeover to enable flexibility between the needs of patients and any unforeseen issues that arose. Staffing rotas within the outpatients department were planned based on a ratio of six nurses to four healthcare assistants.
- From 1 April 2016, the outpatients department had 4.6 full-time equivalent registered nursing staff, and 2.8 full time equivalent health care assistants. Use of registered bank nurses and healthcare assistants varied. Between April 2015 to March 2016, this increased from 2% to 16%. This was comparable to other independent hospitals.
- Four per cent of outpatient healthcare assistants left the service between April 2015 and March 2016; however, during the same period, no nursing staff left. This was lower than other independent hospitals. During our visit the hospital was advertising for one health care assistant post, and was expecting to advertise for a registered nurse position in the near future.

## Medical staffing

- From 1 April 2016, the hospital had 140 doctors and dentists who were directly employed or were practicing under rules of privilege for more than six months. Of these, one radiologist had practicing privileges removed in 2015/2016 following an extensive period of suspension and sickness from their NHS employer. The radiologist had been invited to re-apply for practicing privileges.
- The hospital had one resident medical officer (RMO – this is a doctor who resides at the hospital and is generally on call 24 hours per day seven days per week), who was employed by a third party organisation. A pre-employment training file was provided to the hospital before each RMO arrived, for review and sign-off by matron. This included clinical training, and standard training including advance life support (ALS), European paediatric life support (EPLS), NHS better blood transfusion, infection prevention and control, the mental capacity act and deprivation of liberty safeguards, equality and diversity, child protection (level 3), safeguarding vulnerable adults effective teamwork; data protection, manual handling and fire safety.
- The hospital indicated the RMO usually worked on a ward floor for a maximum of eight to nine hours per 24 hour shift on duty and not receive more than five night calls in a seven day period. There was an escalation process in place to obtain standby relief for a 24 hour rest break, if there was a significant increase in the workload. Whenever possible a doctor who was experienced with the hospital was utilised for 24 hour relief cover.

## Allied healthcare professionals staffing

# Outpatients and diagnostic imaging

- The diagnostic imaging department employed six radiography staff, working a range of hours including full and part-time. There was a small bank of radiographers available to cover unfilled shifts. All bank staff were experienced within the department and had received up-to-date training, risk assessments and were within their documented scope of practice.
- The department had six radiologists, five of whom also worked at a local acute NHS hospital. The radiologists also worked locally at other Ramsay Health Care UK hospitals in the area. They provided on-site cover, but were also able to work remotely from other sites and were available on call for advice. A 'radiologist of the week' service was in place for emergencies and where urgent diagnostic intervention was required.
- The physiotherapy department had 20 staff in total; five of these were contracted by the hospital and the remainder were bank staff. Staff worked flexibly to meet the needs of the department, which included a voluntary weekend rota.

## Major incident awareness and training

- The hospital had a business continuity management policy. Contingency plans were also in place for unexpected events. Staff told us of an example where the radiology department had flooded. This meant that equipment had to be lifted off the floor and subsequently retested.
- Staff had received emergency fire training, and told us that the procedures for this were tested through simulation scenarios. Staff were aware of their responsibilities during a major incident.
- Generators were available if there was a power failure. These were maintained by the hospital's facilities team. Due to the hospital's rural location, staff told us the generators were tested and used regularly.

The hospital was included in regional major incident plans. In the event of a major incident, the hospital's facilities would be used to accept transfers of low acuity patients from other local NHS hospitals. This meant capacity in NHS hospitals could be increased to accept emergency patients.

## Incidents

- The outpatient and diagnostic imaging department (OPD) had 12 clinical incidents between April 2015 and

March 2016. This was less than 0.1 per 100 outpatient attendances (and was lower than other independent hospitals we held data for). There were no diagnostic imaging incidents that required reporting to the regulator in this period.

- There were two non-clinical incidents in the OPD during the same period. This was a rate of less than 0.2 per 100 outpatient attendances (this was again lower than other independent hospitals).
- The hospital had an incident reporting policy in place. This provided definitions of incidents, including near misses and never events, and set out staff responsibilities to report incidents on the hospital's incident recording system within the same shift period. Departmental and corporate managers reviewed incident reports, instigated investigations, put in place corrective actions if necessary, and escalated any risks to senior management. Any incidents with a severity rating of one or two instigated a root cause analysis investigation.
- All clinical, non-clinical, and administrative staff we spoke with were aware of the incident reporting system, and understood their responsibility to report incidents.
- Due to the nature of outpatient consultations and limited treatment, there were no specific safety goals set by the department. However, we were assured that safety of patients was paramount for staff. The head of department told us the department's aim was to ensure 100% safety for all their patients.
- Although there were no serious incidents relating to the outpatient and imaging departments, the hospital had processes in place to carry out root cause analysis of any serious incidents that occurred. This included seeking the views of staff involved in incidents. Analysis used the national patient safety agency 'root cause analysis toolkit' and the 'five whys' technique to analyse the information and to identify the root cause of each incident.
- Lessons from incidents and complaints were shared in a number of ways. Incidents were discussed in local management and heads of department meetings, and regionally in the northern matrons' committee

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meetings. Staff had access to lessons learnt from incidents and complaints via the hospitals computer system, and a hard copy of these was held within the outpatients' nurses' station.

- There were no patient deaths related to care and treatment received in the department. As such, the department was not involved in mortality or morbidity reviews.
- The Ionising Radiation Regulations 1999 (IRR99) requires employers to keep employee exposure to ionising radiations as low as reasonably practicable, and to ensure that exposures must not exceed specified dose limits.
- The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. The current rules were issued in March 2015 and we saw copies for 2013 and 2014. The rules were supported by the hospital's incidents greater than intended exposure of patients caused by procedural error policy. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor (RPS), who in turn logged the incident on the hospital's incident reporting system. The incident was then reported directly to the group's radiation protection advisers for dose calculation, and where necessary to the medical physics expert. The rules and policy also set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive.
- Senior staff were aware of the duty of candour requirements. Operational staff were less aware of the legislative requirements of the duty of candour; however, staff we spoke with were aware of the principles of the duty of being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Although there were no incidents of moderate or severe harm related specifically to the radiology department, staff told us they were asked to provide input into an investigation of a never event in theatre which triggered the duty of candour.

## Cleanliness, infection control and hygiene.

- Cleanliness, infection control and hygiene standards were maintained in the OPD.
- Outpatients, physiotherapy and diagnostic imaging, were visibly tidy and clean with hand gel sanitisers at the entrance of each area. Sanitisers, hand washing facilities and sterile wipes were available in each treatment room. Personal protection apron dispensers were available throughout the department. We saw staff following the 'bare below the elbow' requirement of the policy. Cleaning was carried out by housekeeping staff and cleaning rotas were in place.
- The hospital had a hand hygiene policy in place. The policy was supported by a quarterly observational hand hygiene audit by the infection control link nurse. The policy took into account the hand decontamination guidelines from infection control nurses association, and clean hands saves lives from the national patient safety agency.
- The hospital's hand hygiene audit for July 2015 showed 100% compliance with the requirements of the hospital's policy. This dipped to 88% in October as staff had not used elbows to switch off running taps; a hand hygiene poster was missing; and patients and visitors had not been given the Ramsay Health Care UK hand hygiene leaflet. However, the result increased to 96% in December with only the leaflet being missed, and by April 2016 it had further increased to 99% (again with the leaflet affecting the result).
- The audit results indicated that the hospital complied with the National Institute for Health and Care Excellence (NICE) Quality Standard 61 Statement 3: People receive healthcare from healthcare workers who decontaminated their hands immediately before and after every episode of direct contact or care. However, although staff initials were used to identify those who carried out the audit and those who were observed, there was no indication in the audit results of which areas or departments the audits covered. This meant there was a risk that poor trends in one particular area may not be easily identified.
- In addition, an infection prevention and control environmental audit was carried out each quarter. The results indicated varied compliance between August 2015 and May 2016 (the lowest average compliance rate

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was 88% with the highest compliance 99%). However, the audit results were not always clear about which areas of the hospital the result related to, and did not always detail the corrective actions to be taken. This meant there was an increased risk that infections from environmental issues may not be mitigated.

- The hospital had a standard infection control precautions policy in place, which covered areas including: hand hygiene; use of personal protection equipment; safe use and disposal of sharps; and maintaining a clean environment.
- Infection prevention and control meetings were held every three months, which were supported by quality regional meetings. The meetings included standing items for review of infection incidents in the previous quarter; the outcome of any relevant audits that had been carried out; issues arising from cleaning the environment; general buildings facilities infection control issues; and a review of any relevant updated guidelines and policies.
- A cleaning schedule and log was in place in the radiology department. Staff cleaned clinical equipment after each patient. Non-clinical areas were cleaned by the housekeeping team.
- The hospital had a screening policy for patients who had MRSA (methicillin-resistant staphylococcus aureus). All patients due to receive treatment in the outpatient's department were screened for MRSA. Patients were swabbed and any MRSA positive screening results were notified to the patient's GP. Patients were invited in for eradication therapy and were rescreened before treatment was commenced.
- Within the radiology department patients with MRSA or other suspected communicable infections were allocated appointments at the end of the clinic. If this was not possible, the room would be vacated for 30 minutes after cleaning. Staff also had access to specialist theatre cleaning equipment if needed.
- The hospital carried out decontamination of treatment areas before clinics started. The outpatients department were compliant with the Department of Health's technical memorandum on decontamination of flexible endoscopic scopes, and were no longer using rigid scopes. The remainder of equipment used was disposable.

## Environment and equipment

- The design, maintenance, and use of the facilities and equipment within the department kept people who used the hospital's services safe.
- The outpatients department was located on the ground floor. The open plan waiting area for NHS patients was in the reception area. A separate enclosed waiting room for private patients included coffee making facilities. Both areas were bright, clean, and tidy with comfortable seating.
- There were nine outpatient consultation rooms, which included specialist ear, nose and throat, and eye rooms, a soundproofed audiology room, and a room designated for pre-operative assessments. A number of treatment rooms had trolleys of sterile disposable equipment. We checked a range of equipment held in these; equipment was sealed and within date.
- A resuscitation trolley including an automated defibrillator was available and easily accessible. Daily and monthly checks were carried out of the equipment held on the trolley.
- The diagnostic imaging and physiotherapy departments were also on the ground floor of the hospital and shared a common waiting area. The radiology department carried out on-site plain X-rays, dental X-rays, fluoroscopy, ultrasound scanning, urodynamic testing, and outpatient injection procedures. A mobile X-ray machine was available for obtaining images of patients on the ward in emergencies, and an image intensifier was available in theatre for endoscopy procedures.
- The physiotherapy department, which also supported orthopaedic inpatients, included two individual treatment rooms and a small rehabilitation area including gym equipment. The rehabilitation area could accommodate up to three patients at a time, with privacy curtains between bays. However, staff were concerned that the physical size of the department was small which had led to some patient concerns about privacy.
- The outpatients department had a dirty facility for the disposal of waste. This was clean and tidy, and hazardous cleaning products were locked in cupboards. Clinical waste bags were appropriately classified and were changed by housekeeping staff. There was limited

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equipment used that was not disposable, such as nasopharyngoscope (for viewing internal structures of the nose). Arrangements were in place for decontaminating equipment.

- We reviewed a range of equipment in use within the treatment rooms. Green stickers were in place to identify that equipment had been cleaned and was ready for use. All portable electrical equipment we reviewed had been appropriately tested and labelled with the date when testing would be next required. The hospital's maintenance team held a log of tested equipment.
- Detailed risk assessments were in place for each piece of radiation equipment within the department. These included assessment of risks to staff and patients, staff training in the use of each piece of equipment, signage to ensure mitigation of risks (for example door to be closed), and action plans for maintenance and repair.
- Staff in the department told us they rarely had any issues with faulty equipment, and no clinics were impacted or cancelled because of faulty equipment.
- The diagnostic imaging department had clear signage in place, which included working hazard warning signs outside each area when equipment was being used. The hospital had common policies and procedures in place that set out details of departmental staff responsibilities shared with staff of the mobile magnetic resonance imaging (MRI) and computerised tomography (CT) scanning provider. These included the MRI safety policy, medical emergencies in scanner policy, and medical emergency/arrest on mobile scanner policy.
- Processes were in place to ensure specialised personal protective equipment (PPE) was available and used by staff within the radiology team. All staff members within the radiology department were issued with personal radiation dose monitor badge. Each badge was sent off every three months to be checked centrally, and the individual staff member's dose exposure was recorded.
- Visual and detailed checks of PPE equipment such as lead aprons were carried out, and results were logged. PPE equipment was regularly deep cleaned, and X-ray checks of the PPE equipment was carried out to determine if there were any breaks in the protective material that would lead to inadvertent exposure. PPE equipment checks were included in the departments

audit against the Ionising Radiation Medical Exposure Regulations 2000 [IR(ME)R] and IRR99 regulations. The audit results in February 2016 indicated full compliance by the department.

- The health and safety audit achieved 91% compliance on workplace administration safety; 100% on occupational health and general workplace safety; 96% on plant and equipment; 100% on medical gases and equipment; 100% on COSHH, electrical safety, office areas, manual handling, and first aid; 95% on fire safety and evacuation; 100% on waste disposal, water services, ventilation, decontamination, mechanical, building fabric and systems and management of contractors.
- A contract was in place between Ramsay Health Care UK and a medical equipment and services provider for the maintenance of diagnostic imaging equipment irrespective of the manufacturer of the equipment. This meant equipment was repaired in a timely way. The department also had a system in place for manually recording handover and handback of equipment between the hospital and the engineer. This reduced the likelihood of staff inadvertently using faulty equipment. Routine maintenance was carried out once or twice a year depending on the equipment.
- Staff told us there was an increased need for equipment replacement, but that a business plan would need to be written for this.

## Medicines

- The management of medicines in the department kept people who used the services safe. The hospital had a medicines management policy in place.
- The department did not hold any controlled drugs. Limited medicines and fluids were stored in a locked cupboard in the treatment room. The temperature was recorded using a maximum/minimum thermometer. We reviewed a range of medicines held which were all in date, and appropriately labelled if opened.
- NHS prescription forms, used by consultants, were securely stored in a locked cupboard.
- The radiology department did not hold any controlled medicines; however, there were limited medicines in use in the department as prescribed by the doctor referring the patient. These were stored in a locked cupboard within the X-ray room with maximum/

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minimum thermometers in place and relevant temperature readings recorded. We checked a range of medicines within the cupboard. All medicines were in date and any opened bottles had the date of opening clearly recorded. Oxygen was appropriately stored.

- A service level agreement (SLA) was in place with the pharmacy service of a local acute hospital trust. As part of this, a pharmacist visited the hospital each week to review the storage of medicines. The pharmacists were also available by telephone for advice if needed. A medicines audit was carried out as part of this agreement every month.

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## Nursing staffing

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# Outpatients and diagnostic imaging

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# Outpatients and diagnostic imaging

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- All clinical, non-clinical, and administrative staff we spoke with were aware of the incident reporting system, and understood their responsibility to report incidents.
- Due to the nature of outpatient consultations and limited treatment, there were no specific safety goals set by the department. However, we were assured that safety of patients was paramount for staff. The head of department told us the departments aim was to ensure 100% safety for all their patients.
- Although there were no serious incidents relating to the outpatient and imaging departments, the hospital had processes in place to carry out root cause analysis of any serious incidents that occurred. This included seeking the views of staff involved in incidents. Analysis used the national patient safety agency 'root cause analysis toolkit' and the 'five whys' technique to analyse the information and to identify the root cause of each incident.
- Lessons from incidents and complaints were shared in a number of ways. Incidents were discussed in local management and heads of department meetings, and regionally in the northern matrons' committee meetings. Staff had access to lessons learnt from incidents and complaints via the hospitals computer system, and a hard copy of these was held within the outpatients' nurses' station.
- There were no patient deaths related to care and treatment received in the department. As such, the department was not involved in mortality or morbidity reviews.
- The Ionising Radiation Regulations 1999 (IRR99) requires employers to keep employee exposure to ionising radiations as low as reasonably practicable, and to ensure that exposures must not exceed specified dose limits.
- The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. The current rules were issued in March 2015 and we saw copies for 2013 and 2014. The rules were supported by the hospital's incidents greater than intended exposure of patients caused by procedural error policy. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor (RPS), who in turn logged the incident on the hospital's incident reporting system. The incident was then reported directly to the group's radiation protection advisers for dose calculation, and where necessary to the medical physics expert. The rules and policy also set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive.
- Senior staff were aware of the duty of candour requirements. Operational staff were less aware of the legislative requirements of the duty of candour; however, staff we spoke with were aware of the principles of the duty of being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Although there were no incidents of moderate or severe harm related specifically to the radiology department, staff told us they were asked to provide input into an investigation of a never event in theatre which triggered the duty of candour.

# Outpatients and diagnostic imaging

## Cleanliness, infection control and hygiene.

- Cleanliness, infection control and hygiene standards were maintained in the OPD.
- Outpatients, physiotherapy and diagnostic imaging, were visibly tidy and clean with hand gel sanitisers at the entrance of each area. Sanitisers, hand washing facilities and sterile wipes were available in each treatment room. Personal protection apron dispensers were available throughout the department. We saw staff following the 'bare below the elbow' requirement of the policy. Cleaning was carried out by housekeeping staff and cleaning rotas were in place.
- The hospital had a hand hygiene policy in place. The policy was supported by a quarterly observational hand hygiene audit by the infection control link nurse. The policy took into account the hand decontamination guidelines from infection control nurses association, and clean hands saves lives from the national patient safety agency.
- The hospital's hand hygiene audit for July 2015 showed 100% compliance with the requirements of the hospital's policy. This dipped to 88% in October as staff had not used elbows to switch off running taps; a hand hygiene poster was missing; and patients and visitors had not been given the Ramsay Health Care UK hand hygiene leaflet. However, the result increased to 96% in December with only the leaflet being missed, and by April 2016 it had further increased to 99% (again with the leaflet affecting the result).
- The audit results indicated that the hospital complied with the National Institute for Health and Care Excellence (NICE) Quality Standard 61 Statement 3: People receive healthcare from healthcare workers who decontaminated their hands immediately before and after every episode of direct contact or care. However, although staff initials were used to identify those who carried out the audit and those who were observed, there was no indication in the audit results of which areas or departments the audits covered. This meant there was a risk that poor trends in one particular area may not be easily identified.
- In addition, an infection prevention and control environmental audit was carried out each quarter. The results indicated varied compliance between August 2015 and May 2016 (the lowest average compliance rate was 88% with the highest compliance 99%). However, the audit results were not always clear about which areas of the hospital the result related to, and did not always detail the corrective actions to be taken. This meant there was an increased risk that infections from environmental issues may not be mitigated.
- The hospital had a standard infection control precautions policy in place, which covered areas including: hand hygiene; use of personal protection equipment; safe use and disposal of sharps; and maintaining a clean environment.
- Infection prevention and control meetings were held every three months, which were supported by quality regional meetings. The meetings included standing items for review of infection incidents in the previous quarter; the outcome of any relevant audits that had been carried out; issues arising from cleaning the environment; general buildings facilities infection control issues; and a review of any relevant updated guidelines and policies.
- A cleaning schedule and log was in place in the radiology department. Staff cleaned clinical equipment after each patient. Non-clinical areas were cleaned by the housekeeping team.
- The hospital had a screening policy for patients who had MRSA (methicillin-resistant staphylococcus aureus). All patients due to receive treatment in the outpatient's department were screened for MRSA. Patients were swabbed and any MRSA positive screening results were notified to the patient's GP. Patients were invited in for eradication therapy and were rescreened before treatment was commenced.
- Within the radiology department patients with MRSA or other suspected communicable infections were allocated appointments at the end of the clinic. If this was not possible, the room would be vacated for 30 minutes after cleaning. Staff also had access to specialist theatre cleaning equipment if needed.
- The hospital carried out decontamination of treatment areas before clinics started. The outpatients department were compliant with the Department of Health's technical memorandum on decontamination of flexible endoscopic scopes, and were no longer using rigid scopes. The remainder of equipment used was disposable.

# Outpatients and diagnostic imaging

## Environment and equipment

- The design, maintenance, and use of the facilities and equipment within the department kept people who used the hospitals services safe.
- The outpatients department was located on the ground floor. The open plan waiting area for NHS patients was in the reception area. A separate enclosed waiting room for private patients included coffee making facilities. Both areas were bright, clean, and tidy with comfortable seating.
- There were nine outpatient consultation rooms, which included specialist ear, nose and throat, and eye rooms, a soundproofed audiology room, and a room designated for pre- operative assessments. A number of treatment rooms had trolleys of sterile disposable equipment. We checked a range of equipment held in these; equipment was sealed and within date.
- A resuscitation trolley including an automated defibrillator was available and easily accessible. Daily and monthly checks were carried out of the equipment held on the trolley.
- The diagnostic imaging and physiotherapy departments were also on the ground floor of the hospital and shared a common waiting area. The radiology department carried out on-site plain X-rays, dental X-rays, fluoroscopy, ultrasound scanning, urodynamic testing, and outpatient injection procedures. A mobile X-ray machine was available for obtaining images of patients on the ward in emergencies, and an image intensifier was available in theatre for endoscopy procedures.
- The physiotherapy department, which also supported orthopaedic inpatients, included two individual treatment rooms and a small rehabilitation area including gym equipment. The rehabilitation area could accommodate up to three patients at a time, with privacy curtains between bays. However, staff were concerned that the physical size of the department was small which had led to some patient concerns about privacy.
- The outpatients department had a dirty facility for the disposal of waste. This was clean and tidy, and hazardous cleaning products were locked in cupboards. Clinical waste bags were appropriately classified and were changed by housekeeping staff. There was limited equipment used that was not disposable, such as nasopharyngoscope (for viewing internal structures of the nose). Arrangements were in place for decontaminating equipment.
- We reviewed a range of equipment in use within the treatment rooms. Green stickers were in place to identify that equipment had been cleaned and was ready for use. All portable electrical equipment we reviewed had been appropriately tested and labelled with the date when testing would be next required. The hospitals maintenance team held a log of tested equipment.
- Detailed risk assessments were in place for each piece of radiation equipment within the department. These included assessment of risks to staff and patients, staff training in the use of each piece of equipment, signage to ensure mitigation of risks (for example door to be closed), and action plans for maintenance and repair.
- Staff in the department told us they rarely had any issues with faulty equipment, and no clinics were impacted or cancelled because of faulty equipment.
- The diagnostic imaging department had clear signage in place, which included working hazard warning signs outside each area when equipment was being used. The hospital had common policies and procedures in place that set out details of departmental staff responsibilities shared with staff of the mobile magnetic resonance imaging (MRI) and computerised tomography (CT) scanning provider. These included the MRI safety policy, medical emergencies in scanner policy, and medical emergency/arrest on mobile scanner policy.
- Processes were in place to ensure specialised personal protective equipment (PPE) was available and used by staff within the radiology team. All staff members within the radiology department were issued with personal radiation dose monitor badge. Each badge was sent off every three months to be checked centrally, and the individual staff member's dose exposure was recorded.
- Visual and detailed checks of PPE equipment such as lead aprons were carried out, and results were logged. PPE equipment was regularly deep cleaned, and X-ray checks of the PPE equipment was carried out to determine if there were any breaks in the protective material that would lead to inadvertent exposure. PPE equipment checks were included in the departments

# Outpatients and diagnostic imaging

audit against the Ionising Radiation Medical Exposure Regulations 2000 [IR(ME)R] and IRR99 regulations. The audit results in February 2016 indicated full compliance by the department.

- The health and safety audit achieved 91% compliance on workplace administration safety; 100% on occupational health and general workplace safety; 96% on plant and equipment; 100% on medical gases and equipment; 100% on COSHH, electrical safety, office areas, manual handling, and first aid; 95% on fire safety and evacuation; 100% on waste disposal, water services, ventilation, decontamination, mechanical, building fabric and systems and management of contractors.
- A contract was in place between Ramsay Health Care UK and a medical equipment and services provider for the maintenance of diagnostic imaging equipment irrespective of the manufacturer of the equipment. This meant equipment was repaired in a timely way. The department also had a system in place for manually recording handover and handback of equipment between the hospital and the engineer. This reduced the likelihood of staff inadvertently using faulty equipment. Routine maintenance was carried out once or twice a year depending on the equipment.
- Staff told us there was an increased need for equipment replacement, but that a business plan would need to be written for this.

## Medicines

- The management of medicines in the department kept people who used the services safe. The hospital had a medicines management policy in place.
- The department did not hold any controlled drugs. Limited medicines and fluids were stored in a locked cupboard in the treatment room. The temperature was recorded using a maximum/minimum thermometer. We reviewed a range of medicines held which were all in date, and appropriately labelled if opened.
- NHS prescription forms, used by consultants, were securely stored in a locked cupboard.
- The radiology department did not hold any controlled medicines; however, there were limited medicines in use in the department as prescribed by the doctor referring the patient. These were stored in a locked cupboard within the X-ray room with maximum/

minimum thermometers in place and relevant temperature readings recorded. We checked a range of medicines within the cupboard. All medicines were in date and any opened bottles had the date of opening clearly recorded. Oxygen was appropriately stored.

- A service level agreement (SLA) was in place with the pharmacy service of a local acute hospital trust. As part of this, a pharmacist visited the hospital each week to review the storage of medicines. The pharmacists were also available by telephone for advice if needed. A medicines audit was carried out as part of this agreement every month.

## Records

- There were systems and processes in place in the department to ensure the management of people's records were accurate, complete, legible, up to date and stored securely.
- The hospital had ISO20071 information security accreditation and was audited on compliance against this. The hospital had current action plans in place to address minor non-compliance issues that had been highlighted in the 2016 audit.
- The hospital had a medical records management policy in place, which took into account the requirements of the data protection act 1998, and the access to health records act 1990. This set out responsibilities for all staff members in the creation, handling, storage and destruction of records. It also detailed standards for confidentiality and set out rights to access records. The policy was supported by a Caldicott guardian policy, based on the seven Caldicott principles.
- Any incidents relating to information security were recorded on the hospital's incident reporting system. Information incidents were reviewed by the corporate information governance committee and were monitored by the information governance manager.
- We reviewed five patient care records within the outpatients department. All were of good quality. Referrals, relevant history, patient consent, plans of care, decisions and, where appropriate, discharge summaries were all clearly recorded.
- There was a clear and robust process in place for the storage and movement of records within the department. Records needed for each clinic were

# Outpatients and diagnostic imaging

transferred to the department from medical records in the morning and afternoon. Whilst within the department, records were securely stored. The hospital did not permit records to be taken off-site, and all staff including consultants were aware of this policy. This meant that all records, including those created by consultants with practicing privileges, remained securely on site.

- The hospital reported that only one per cent of records were not available for clinic appointments. Staff told us that, in this situation, they printed any electronic letters held and placed into a temporary record for the consultant to use in clinic. Temporary records were subsequently destroyed.
- The hospital was in the process of introducing an electronic patient record system; however, this was still in the process of being implemented at the time of our inspection.
- The diagnostic imaging department held records within the PACS (picture archiving and communication system) electronic system. Referring consultants also had access to this system which meant that copies of the images and the radiology reports were directly available to consultants. The department had a procedure in place for requesting access to patient images held by other healthcare organisations through the PACS image exchange portal system if needed.
- A medical records audit programme was in place which carried out checks every month. This showed a compliance rate of between 89% and 97% (with one outlier at 65%) between July 2015 and April 2016. The audits included actions taken to improve, the responsible person, and date for completion. However, the results do not clearly indicate which department the audit related to.
- We reviewed two patient records for the physiotherapy department's acupuncture clinic. Both included appropriate and clear information, including referrals, a brief pain inventory and visual score assessment, and completed consent forms.
- A process was in place for clinics where notes were not available to the consultant. There were no reported clinic cancellations within the department because of records not being available.

- When transported off site, patient records were kept in lockable cases.

## Safeguarding

- The hospital had safeguarding systems and processes in place to ensure that people were kept safe. Staff received safeguarding training, and knew how they could obtain further advice.
- The hospital had a safeguarding adults at risk of abuse or neglect policy, which was based on a number of guidelines from professional bodies and the Department of Health.
- The policy covered a range of safeguarding issues including domestic abuse and female genital mutilation (FGM). Flowchart pathways were provided to guide staff on the appropriate response to safeguarding or FGM concerns. Copies of the flowcharts were clearly displayed within the nursing office.
- The hospital had a number of on-site adult safeguarding leads, who included the matron, the medical advisory committee chairperson, the ward manager, the quality improvement lead, the ward sister, and the outpatients' team leader. The hospital's safeguarding leads had received safeguarding level three training in safeguarding children and young people; all clinical staff had level two training, and all non-clinical staff had level one training. All staff had also received training in safeguarding of vulnerable adults. This meant that staff were able to recognise and report, or obtain additional advice, if they identified a potential safeguarding concern.
- Although a decision was made to stop treating children at the hospital in December 2015, staff recognised the need to maintain level three safeguarding training as children often accompanied adult patients.
- Clinical, non-clinical and administration staff were all aware of the types of issues that may need to be reported as a safeguarding concern or alert. Staff were aware of the process to follow to obtain advice from the leads, or to raise a safeguarding concern or alert via the hospital's incident reporting system. Posters providing information relating to safeguarding were displayed in staff areas.

## Mandatory training

# Outpatients and diagnostic imaging

- The hospital had a mandatory training policy. This was supported by a mandatory training matrix. Training was delivered through e-learning packages for: data protection; emergency management: fire and personal safety; equality, human rights & workplace diversity; health and safety; prevention of infection; information security; manual handling; non-clinical basic life support; clinical basic life support; and child protection. The policy set out employee's responsibility to ensure mandatory training was completed each year and detailed sanctions that would imply for non-completion, including potential disciplinary action.
- A tracker was used in conjunction with the training matrix to ensure that staff completed mandatory training. This highlighted when modules were due for renewal.
- Mandatory training completion was high for staff in the department, with only two staff that had yet to complete dementia training.
- All staff, including bank and agency staff, completed an induction training programme.
- In line with the IR(ME)R regulations, and the hospital's policy, a training record was kept for all non-medical referrers' scope of practice and entitlement to refer for imaging. Ten physiotherapists in the hospital had entitlement to refer patients for imaging.
- All staff had recently signed to confirm they had received up to date training and knowledge in line with the regulations. Although two entries for bank radiographer staff had yet to be signed, this was because the individuals involved had not been on duty since. The service lead told us these bank staff would be asked to sign when they were next on duty.
- Clear, illuminated, "radiation in use" warning signs were in place by doors leading into any area where radiation equipment was used.
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## Assessing and responding to patient risk

- The department had a resuscitation trolley available for use in emergencies. A dedicated internal telephone was in place for alerting staff to emergencies. This was also provided to staff of the other healthcare provider who operated the mobile computerised tomography (CT) and magnetic resonance imaging (MR) scanners.
- Risk assessments, including control of substances hazardous to health (COSHH) risk assessments, were in place for equipment and chemicals in use within the outpatients department. We reviewed a number of these which were detailed and up to date.
- The hospital had two radiation protection supervisors. The supervisors were supported by Ramsay Health Care UK radiation protection advisers, who were based in St Georges Hospital in London. The advisers were available on call to provide advice.
- A radiation protection adviser audit was carried out every year. The most recent audit made five recommendations; all of which had been implemented and the hospital had taken appropriate action to address shortfalls.
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- The hospital had an incident reporting policy in place. This provided definitions of incidents, including near misses and never events, and set out staff responsibilities to report incidents on the hospital's incident recording system within the same shift period. Departmental and corporate managers reviewed incident reports, instigated investigations, put in place corrective actions if necessary, and escalated any risks to senior management. Any incidents with a severity rating of one or two instigated a root cause analysis investigation.
- All clinical, non-clinical, and administrative staff we spoke with were aware of the incident reporting system, and understood their responsibility to report incidents.
- Due to the nature of outpatient consultations and limited treatment, there were no specific safety goals set by the department. However, we were assured that safety of patients was paramount for staff. The head of department told us the department's aim was to ensure 100% safety for all their patients.
- Although there were no serious incidents relating to the outpatient and imaging departments, the hospital had processes in place to carry out root cause analysis of any serious incidents that occurred. This included seeking the views of staff involved in incidents. Analysis used the national patient safety agency 'root cause analysis toolkit' and the 'five whys' technique to analyse the information and to identify the root cause of each incident.
- Lessons from incidents and complaints were shared in a number of ways. Incidents were discussed in local management and heads of department meetings, and regionally in the northern matrons' committee

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meetings. Staff had access to lessons learnt from incidents and complaints via the hospitals computer system, and a hard copy of these was held within the outpatients' nurses' station.

- There were no patient deaths related to care and treatment received in the department. As such, the department was not involved in mortality or morbidity reviews.
- The Ionising Radiation Regulations 1999 (IRR99) requires employers to keep employee exposure to ionising radiations as low as reasonably practicable, and to ensure that exposures must not exceed specified dose limits.
- The hospital held a copy of 'local rules' that were in place to meet the IRR99 regulations. The current rules were issued in March 2015 and we saw copies for 2013 and 2014. The rules were supported by the hospital's incidents greater than intended exposure of patients caused by procedural error policy. These set out the responsibility of staff to report exposure incidents to the on-site radiation protection supervisor (RPS), who in turn logged the incident on the hospital's incident reporting system. The incident was then reported directly to the group's radiation protection advisers for dose calculation, and where necessary to the medical physics expert. The rules and policy also set out the dose thresholds for reporting radiation exposure incidents to the CQC and/or the Health and Safety Executive.
- Senior staff were aware of the duty of candour requirements. Operational staff were less aware of the legislative requirements of the duty of candour; however, staff we spoke with were aware of the principles of the duty of being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Although there were no incidents of moderate or severe harm related specifically to the radiology department, staff told us they were asked to provide input into an investigation of a never event in theatre which triggered the duty of candour.

## Cleanliness, infection control and hygiene.

- Cleanliness, infection control and hygiene standards were maintained in the OPD.
- Outpatients, physiotherapy and diagnostic imaging, were visibly tidy and clean with hand gel sanitisers at the entrance of each area. Sanitisers, hand washing facilities and sterile wipes were available in each treatment room. Personal protection apron dispensers were available throughout the department. We saw staff following the 'bare below the elbow' requirement of the policy. Cleaning was carried out by housekeeping staff and cleaning rotas were in place.
- The hospital had a hand hygiene policy in place. The policy was supported by a quarterly observational hand hygiene audit by the infection control link nurse. The policy took into account the hand decontamination guidelines from infection control nurses association, and clean hands saves lives from the national patient safety agency.
- The hospital's hand hygiene audit for July 2015 showed 100% compliance with the requirements of the hospital's policy. This dipped to 88% in October as staff had not used elbows to switch off running taps; a hand hygiene poster was missing; and patients and visitors had not been given the Ramsay Health Care UK hand hygiene leaflet. However, the result increased to 96% in December with only the leaflet being missed, and by April 2016 it had further increased to 99% (again with the leaflet affecting the result).
- The audit results indicated that the hospital complied with the National Institute for Health and Care Excellence (NICE) Quality Standard 61 Statement 3: People receive healthcare from healthcare workers who decontaminated their hands immediately before and after every episode of direct contact or care. However, although staff initials were used to identify those who carried out the audit and those who were observed, there was no indication in the audit results of which areas or departments the audits covered. This meant there was a risk that poor trends in one particular area may not be easily identified.
- In addition, an infection prevention and control environmental audit was carried out each quarter. The results indicated varied compliance between August 2015 and May 2016 (the lowest average compliance rate

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was 88% with the highest compliance 99%). However, the audit results were not always clear about which areas of the hospital the result related to, and did not always detail the corrective actions to be taken. This meant there was an increased risk that infections from environmental issues may not be mitigated.

- The hospital had a standard infection control precautions policy in place, which covered areas including: hand hygiene; use of personal protection equipment; safe use and disposal of sharps; and maintaining a clean environment.
- Infection prevention and control meetings were held every three months, which were supported by quality regional meetings. The meetings included standing items for review of infection incidents in the previous quarter; the outcome of any relevant audits that had been carried out; issues arising from cleaning the environment; general buildings facilities infection control issues; and a review of any relevant updated guidelines and policies.
- A cleaning schedule and log was in place in the radiology department. Staff cleaned clinical equipment after each patient. Non-clinical areas were cleaned by the housekeeping team.
- The hospital had a screening policy for patients who had MRSA (methicillin-resistant staphylococcus aureus). All patients due to receive treatment in the outpatient's department were screened for MRSA. Patients were swabbed and any MRSA positive screening results were notified to the patient's GP. Patients were invited in for eradication therapy and were rescreened before treatment was commenced.
- Within the radiology department patients with MRSA or other suspected communicable infections were allocated appointments at the end of the clinic. If this was not possible, the room would be vacated for 30 minutes after cleaning. Staff also had access to specialist theatre cleaning equipment if needed.
- The hospital carried out decontamination of treatment areas before clinics started. The outpatients department were compliant with the Department of Health's technical memorandum on decontamination of flexible endoscopic scopes, and were no longer using rigid scopes. The remainder of equipment used was disposable.

## Environment and equipment

- The design, maintenance, and use of the facilities and equipment within the department kept people who used the hospital's services safe.
- The outpatients department was located on the ground floor. The open plan waiting area for NHS patients was in the reception area. A separate enclosed waiting room for private patients included coffee making facilities. Both areas were bright, clean, and tidy with comfortable seating.
- There were nine outpatient consultation rooms, which included specialist ear, nose and throat, and eye rooms, a soundproofed audiology room, and a room designated for pre-operative assessments. A number of treatment rooms had trolleys of sterile disposable equipment. We checked a range of equipment held in these; equipment was sealed and within date.
- A resuscitation trolley including an automated defibrillator was available and easily accessible. Daily and monthly checks were carried out of the equipment held on the trolley.
- The diagnostic imaging and physiotherapy departments were also on the ground floor of the hospital and shared a common waiting area. The radiology department carried out on-site plain X-rays, dental X-rays, fluoroscopy, ultrasound scanning, urodynamic testing, and outpatient injection procedures. A mobile X-ray machine was available for obtaining images of patients on the ward in emergencies, and an image intensifier was available in theatre for endoscopy procedures.
- The physiotherapy department, which also supported orthopaedic inpatients, included two individual treatment rooms and a small rehabilitation area including gym equipment. The rehabilitation area could accommodate up to three patients at a time, with privacy curtains between bays. However, staff were concerned that the physical size of the department was small which had led to some patient concerns about privacy.
- The outpatients department had a dirty facility for the disposal of waste. This was clean and tidy, and hazardous cleaning products were locked in cupboards. Clinical waste bags were appropriately classified and were changed by housekeeping staff. There was limited

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equipment used that was not disposable, such as nasopharyngoscope (for viewing internal structures of the nose). Arrangements were in place for decontaminating equipment.

- We reviewed a range of equipment in use within the treatment rooms. Green stickers were in place to identify that equipment had been cleaned and was ready for use. All portable electrical equipment we reviewed had been appropriately tested and labelled with the date when testing would be next required. The hospital's maintenance team held a log of tested equipment.
- Detailed risk assessments were in place for each piece of radiation equipment within the department. These included assessment of risks to staff and patients, staff training in the use of each piece of equipment, signage to ensure mitigation of risks (for example door to be closed), and action plans for maintenance and repair.
- Staff in the department told us they rarely had any issues with faulty equipment, and no clinics were impacted or cancelled because of faulty equipment.
- The diagnostic imaging department had clear signage in place, which included working hazard warning signs outside each area when equipment was being used. The hospital had common policies and procedures in place that set out details of departmental staff responsibilities shared with staff of the mobile magnetic resonance imaging (MRI) and computerised tomography (CT) scanning provider. These included the MRI safety policy, medical emergencies in scanner policy, and medical emergency/arrest on mobile scanner policy.
- Processes were in place to ensure specialised personal protective equipment (PPE) was available and used by staff within the radiology team. All staff members within the radiology department were issued with personal radiation dose monitor badge. Each badge was sent off every three months to be checked centrally, and the individual staff member's dose exposure was recorded.
- Visual and detailed checks of PPE equipment such as lead aprons were carried out, and results were logged. PPE equipment was regularly deep cleaned, and X-ray checks of the PPE equipment was carried out to determine if there were any breaks in the protective material that would lead to inadvertent exposure. PPE equipment checks were included in the departments

audit against the Ionising Radiation Medical Exposure Regulations 2000 [IR(ME)R] and IRR99 regulations. The audit results in February 2016 indicated full compliance by the department.

- The health and safety audit achieved 91% compliance on workplace administration safety; 100% on occupational health and general workplace safety; 96% on plant and equipment; 100% on medical gases and equipment; 100% on COSHH, electrical safety, office areas, manual handling, and first aid; 95% on fire safety and evacuation; 100% on waste disposal, water services, ventilation, decontamination, mechanical, building fabric and systems and management of contractors.
- A contract was in place between Ramsay Health Care UK and a medical equipment and services provider for the maintenance of diagnostic imaging equipment irrespective of the manufacturer of the equipment. This meant equipment was repaired in a timely way. The department also had a system in place for manually recording handover and handback of equipment between the hospital and the engineer. This reduced the likelihood of staff inadvertently using faulty equipment. Routine maintenance was carried out once or twice a year depending on the equipment.
- Staff told us there was an increased need for equipment replacement, but that a business plan would need to be written for this.

## Medicines

- The management of medicines in the department kept people who used the services safe. The hospital had a medicines management policy in place.
- The department did not hold any controlled drugs. Limited medicines and fluids were stored in a locked cupboard in the treatment room. The temperature was recorded using a maximum/minimum thermometer. We reviewed a range of medicines held which were all in date, and appropriately labelled if opened.
- NHS prescription forms, used by consultants, were securely stored in a locked cupboard.
- The radiology department did not hold any controlled medicines; however, there were limited medicines in use in the department as prescribed by the doctor referring the patient. These were stored in a locked cupboard within the X-ray room with maximum/

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minimum thermometers in place and relevant temperature readings recorded. We checked a range of medicines within the cupboard. All medicines were in date and any opened bottles had the date of opening clearly recorded. Oxygen was appropriately stored.

- A service level agreement (SLA) was in place with the pharmacy service of a local acute hospital trust. As part of this, a pharmacist visited the hospital each week to review the storage of medicines. The pharmacists were also available by telephone for advice if needed. A medicines audit was carried out as part of this agreement every month.

## Records

- There were systems and processes in place in the department to ensure the management of people's records were accurate, complete, legible, up to date and stored securely.
- The hospital had ISO20071 information security accreditation and was audited on compliance against this. The hospital had current action plans in place to address minor non-compliance issues that had been highlighted in the 2016 audit.
- The hospital had a medical records management policy in place, which took into account the requirements of the data protection act 1998, and the access to health records act 1990. This set out responsibilities for all staff members in the creation, handling, storage and destruction of records. It also detailed standards for confidentiality and set out rights to access records. The policy was supported by a Caldicott guardian policy, based on the seven Caldicott principles.
- Any incidents relating to information security were recorded on the hospital's incident reporting system. Information incidents were reviewed by the corporate information governance committee and were monitored by the information governance manager.
- We reviewed five patient care records within the outpatients department. All were of good quality. Referrals, relevant history, patient consent, plans of care, decisions and, where appropriate, discharge summaries were all clearly recorded.
- There was a clear and robust process in place for the storage and movement of records within the department. Records needed for each clinic were transferred to the department from medical records in the morning and afternoon. Whilst within the department, records were securely stored. The hospital did not permit records to be taken off-site, and all staff including consultants were aware of this policy. This meant that all records, including those created by consultants with practicing privileges, remained securely on site.
- The hospital reported that only one per cent of records were not available for clinic appointments. Staff told us that, in this situation, they printed any electronic letters held and placed into a temporary record for the consultant to use in clinic. Temporary records were subsequently destroyed.
- The hospital was in the process of introducing an electronic patient record system; however, this was still in the process of being implemented at the time of our inspection.
- The diagnostic imaging department held records within the PACS (picture archiving and communication system) electronic system. Referring consultants also had access to this system which meant that copies of the images and the radiology reports were directly available to consultants. The department had a procedure in place for requesting access to patient images held by other healthcare organisations through the PACS image exchange portal system if needed.
- A medical records audit programme was in place which carried out checks every month. This showed a compliance rate of between 89% and 97% (with one outlier at 65%) between July 2015 and April 2016. The audits included actions taken to improve, the responsible person, and date for completion. However, the results do not clearly indicate which department the audit related to.
- We reviewed two patient records for the physiotherapy department's acupuncture clinic. Both included appropriate and clear information, including referrals, a brief pain inventory and visual score assessment, and completed consent forms.
- A process was in place for clinics where notes were not available to the consultant. There were no reported clinic cancellations within the department because of records not being available.

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- When transported off site, patient records were kept in lockable cases.

## Safeguarding

- The hospital had safeguarding systems and processes in place to ensure that people were kept safe. Staff received safeguarding training, and knew how they could obtain further advice.
- The hospital had a safeguarding adults at risk of abuse or neglect policy, which was based on a number of guidelines from professional bodies and the Department of Health.
- The policy covered a range of safeguarding issues including domestic abuse and female genital mutilation (FGM). Flowchart pathways were provided to guide staff on the appropriate response to safeguarding or FGM concerns. Copies of the flowcharts were clearly displayed within the nursing office.
- The hospital had a number of on-site adult safeguarding leads, who included the matron, the medical advisory committee chairperson, the ward manager, the quality improvement lead, the ward sister, and the outpatients' team leader. The hospital's safeguarding leads had received safeguarding level three training in safeguarding children and young people; all clinical staff had level two training, and all non-clinical staff had level one training. All staff had also received training in safeguarding of vulnerable adults. This meant that staff were able to recognise and report, or obtain additional advice, if they identified a potential safeguarding concern.
- Although a decision was made to stop treating children at the hospital in December 2015, staff recognised the need to maintain level three safeguarding training as children often accompanied adult patients.
- Clinical, non-clinical and administration staff were all aware of the types of issues that may need to be reported as a safeguarding concern or alert. Staff were aware of the process to follow to obtain advice from the leads, or to raise a safeguarding concern or alert via the hospital's incident reporting system. Posters providing information relating to safeguarding were displayed in staff areas.

## Mandatory training

- The hospital had a mandatory training policy. This was supported by a mandatory training matrix. Training was delivered through e-learning packages for: data protection; emergency management: fire and personal safety; equality, human rights & workplace diversity; health and safety; prevention of infection; information security; manual handling; non-clinical basic life support; clinical basic life support; and child protection. The policy set out employee's responsibility to ensure mandatory training was completed each year and detailed sanctions that would imply for non-completion, including potential disciplinary action.
- A tracker was used in conjunction with the training matrix to ensure that staff completed mandatory training. This highlighted when modules were due for renewal.
- Mandatory training completion was high for staff in the department, with only two staff that had yet to complete dementia training.
- All staff, including bank and agency staff, completed an induction training programme.

## Assessing and responding to patient risk

- The department had a resuscitation trolley available for use in emergencies. A dedicated internal telephone was in place for alerting staff to emergencies. This was also provided to staff of the other healthcare provider who operated the mobile computerised tomography (CT) and magnetic resonance imaging (MR) scanners.
- Risk assessments, including control of substances hazardous to health (COSHH) risk assessments, were in place for equipment and chemicals in use within the outpatients department. We reviewed a number of these which were detailed and up to date.
- The hospital had two radiation protection supervisors. The supervisors were supported by Ramsay Health Care UK radiation protection advisers, who were based in St Georges Hospital in London. The advisers were available on call to provide advice.
- A radiation protection adviser audit was carried out every year. The most recent audit made five recommendations; all of which had been implemented and the hospital had taken appropriate action to address shortfalls.

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- In line with the IR(ME)R regulations, and the hospital's policy, a training record was kept for all non-medical referrers' scope of practice and entitlement to refer for imaging. Ten physiotherapists in the hospital had entitlement to refer patients for imaging.
- All staff had recently signed to confirm they had received up to date training and knowledge in line with the regulations. Although two entries for bank radiographer staff had yet to be signed, this was because the individuals involved had not been on duty since. The service lead told us these bank staff would be asked to sign when they were next on duty.
- Clear, illuminated, "radiation in use" warning signs were in place by doors leading into any area where radiation equipment was used.
- The hospital had an examination of females of child bearing age policy, which included a pathway flowchart for staff to follow. However, staff in the radiology department told us that they do not carry out X-rays or scans on pregnant women. Warnings signs asking patients to tell staff if they may be pregnant were clearly displayed on doors into radiation controlled areas.
- A clinical radiology contrast agent and medicines for diagnostic imaging policy was in place. This included a treatment pathway that was based on the Royal College of Radiologists guidelines on the use of contrast agents (dyes used in radiology to improve the visibility of internal bodily structures). Blood tests were carried out on patients at risk of acute kidney injury, such as those with patients with diabetes. Where the test results were abnormal, the radiologist decided on what action to take.
- Diagnostic imaging staff provided two examples of where issues of risk had been addressed. The first related to an increased number of requests for mobile X-rays to be carried out on the in-patient ward when the patients were not in a critical or urgent condition. This meant that there was an increased risk of radiation exposure to other patients, and increased environment radiation levels. This was raised as a radiation protection issue with the matron and a standard operating procedure with strict criteria was put in place. Staff told us that the number of mobile X-ray requests had since reduced dramatically.
- The second example related to patients who were discharged by consultants before they had received post-operative X-rays. A reminder about this was sent to the consultant, which also drew on the hospital's values 'The Ramsay Way'.
- The diagnostic imaging department had an unexpected findings / significant pathology policy. This meant abnormal findings during imaging were appropriately highlighted to the radiologist, who discussed these with the patient. If transfer to an acute NHS hospital was indicated, this was arranged.
- The diagnostic imaging department had experienced two such cases recently where staff arranged immediate emergency transfer to hospital in line with the policy.

## Nursing staffing

- Staffing levels were planned and reviewed using an electronic rostering management system which embedded indicators for safety and effectiveness. This enabled heads of departments to manage rotas, shift allocations, annual leave and sick absences, skill mix and staff requirements including senior cover. The system provided indicators of safety and effectiveness and allowed heads of departments to manage shift allocation, annual leave and sickness absence.
- Staffing levels were planned a week in advance and reviewed on a daily basis and again at shift changeover to enable flexibility between the needs of patients and any unforeseen issues that arose. Staffing rotas within the outpatients department were planned based on a ratio of six nurses to four healthcare assistants.
- From 1 April 2016, the outpatients department had 4.6 full-time equivalent registered nursing staff, and 2.8 full time equivalent health care assistants. Use of registered bank nurses and healthcare assistants varied. Between April 2015 to March 2016, this increased from 2% to 16%. This was comparable to other independent hospitals.
- Four per cent of outpatient healthcare assistants left the service between April 2015 and March 2016; however, during the same period, no nursing staff left. This was lower than other independent hospitals. During our visit the hospital was advertising for one health care assistant post, and was expecting to advertise for a registered nurse position in the near future.



# Outpatients and diagnostic imaging

- There were no days lost in the outpatient department to nursing staff sickness during the period April 2015 to March 2016, and there were no unfilled shifts in the first three months of 2016. The sickness rate was lower than other independent hospitals where data is held.
- The hospital had an induction policy, which was supported by an induction booklet and checklist. The policy set out the responsibilities of all relevant staff members, including the new employee. New starters met with their line manager to review performance against the induction programme at frequent intervals in line with the policy.

## Medical staffing

- From 1 April 2016, the hospital had 140 doctors and dentists who were directly employed or were practicing under rules of privilege for more than six months. Of these, one radiologist had practicing privileges removed in 2015/2016 following an extensive period of suspension and sickness from their NHS employer. The radiologist had been invited to re-apply for practicing privileges.
  - The hospital had one resident medical officer (RMO – this is a doctor who resides at the hospital and is generally on call 24 hours per day seven days per week), who was employed by a third party organisation. A pre-employment training file was provided to the hospital before each RMO arrived, for review and sign-off by matron. This included clinical training, and standard training including advance life support (ALS), European paediatric life support (EPLS), NHS better blood transfusion, infection prevention and control, the mental capacity act and deprivation of liberty safeguards, equality and diversity, child protection (level 3), safeguarding vulnerable adults effective teamwork; data protection, manual handling and fire safety.
  - The hospital indicated the RMO usually worked on a ward floor for a maximum of eight to nine hours per 24 hour shift on duty and not receive more than five night calls in a seven day period. There was an escalation process in place to obtain standby relief for a 24 hour rest break, if there was a significant increase in the workload. Whenever possible a doctor who was experienced with the hospital was utilised for 24 hour relief cover.
- The diagnostic imaging department employed six radiography staff, working a range of hours including full and part-time. There was a small bank of radiographers available to cover unfilled shifts. All bank staff were experienced within the department and had received up-to-date training, risk assessments and were within their documented scope of practice.
  - The department had six radiologists, five of whom also worked at a local acute NHS hospital. The radiologists also worked locally at other Ramsay Health Care UK hospitals in the area. They provided on-site cover, but were also able to work remotely from other sites and were available on call for advice. A 'radiologist of the week' service was in place for emergencies and where urgent diagnostic intervention was required.
  - The physiotherapy department had 20 staff in total; five of these were contracted by the hospital and the remainder were bank staff. Staff worked flexibly to meet the needs of the department, which included a voluntary weekend rota.

## Major incident awareness and training

- The hospital had a business continuity management policy. Contingency plans were also in place for unexpected events. Staff told us of an example where the radiology department had flooded. This meant that equipment had to be lifted off the floor and subsequently retested.
- Staff had received emergency fire training, and told us that the procedures for this were tested through simulation scenarios. Staff were aware of their responsibilities during a major incident.
- Generators were available if there was a power failure. These were maintained by the hospital's facilities team. Due to the hospital's rural location, staff told us the generators were tested and used regularly.
- The hospital was included in regional major incident plans. In the event of a major incident, the hospital's facilities would be used to accept transfers of low acuity patients from other local NHS hospitals. This meant capacity in NHS hospitals could be increased to accept emergency patients.

## Allied healthcare professionals staffing

# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

We inspected but have not rated the outpatients and diagnostic imaging services at Renacres Hospital. This is because we are not

### Evidence-based care and treatment

- Care and treatment was delivered in the department in line with legislation, standards and evidence based guidance.
- The hospital's policies and protocols were standardised at corporate level. They incorporated up to date recommendations and guidelines from the national institute for health and care excellence (NICE) and other professional bodies including the relevant Royal Colleges.
- Updated clinical guidance was reviewed at national level, and fed back to staff through the hospital's clinical governance and medical advisory committees.
- The pain management and acupuncture clinics were developed in line with the NICE guidance on the early management of lower back pain.
- Patient clinical pathways were also standardised. These took into account guidance and established practice. Specific pathway documents were used for each procedure.
- Diagnostic imaging procedures were carried out in line with established practice from the Royal College of Radiologists, the Ionising Radiation Medical Exposure Regulations 2000, and the Ionising Radiations Regulations 1999.
- Physiotherapy treatment was provided in line with established practice and guidance from the Chartered Society of Physiotherapy. Physiotherapy care and treatment was audited against the society's quality assurance standards audit tool.

### Pain relief

- The outpatient and physiotherapy departments used the corporate pain assessment tool and analgesia ladder to assess patients' pain, and to determine if any change to prescribed analgesia was needed.
- The physiotherapy department had developed and introduced a back pain management service and an acupuncture clinic. Three consultant pain specialists, one of whom was a consultant anaesthetist, and a consultant spinal surgeon, delivered the service. The physiotherapy and outpatient nursing team supported the medical team.
- The pain service provided two types of injection treatments for back pain; injection into the weight bearing joints of the spine between two vertebrae, and nerve block injections under X-ray guidance.
- Outreach pain management clinics were provided in GP surgeries in the Skelmersdale, Formby and Wigan areas. This meant the service was able to see patients closer to their homes.
- The consultants and staff were aiming to develop the pain service further. There were physical limitations in the size of the available facilities; however, additional afternoon classes for knee pain were being considered to try to improve patient access to the service. The physiotherapy manager set up a hand physiotherapy group across all the Ramsay Health Care UK hospitals in the northwest.
- The acupuncture service used a brief pain inventory with patients on their first therapy session. This was a simple form to gauge a patient's level of pain.
- The inventory was supported by a visual analogue scale, where patients indicated each week an estimation of the level of pain they were experiencing at that time. This information was collated by the service over a twelve-month period, with a view to presenting learning from it to the team.
- The service aimed to introduce a monthly 'talk' for patients with chronic pain. This would discuss issues around how emotions and stress levels can influence levels of pain experienced.

### Patient outcomes

- The physiotherapy department recognised that measuring patient outcomes was an area that needed

# Outpatients and diagnostic imaging

to be improved. Although physiotherapists recorded progress towards patient goals as one measurable outcome, the physiotherapy manager was in the process of trying to find an appropriate tool to measure patient outcomes going forward.

- However, the hospital's patient satisfaction survey for June 2016 showed that 100% of respondents who had received physiotherapy treatment said they had experienced an improvement in their condition. This was against a rolling quarter figure of 93.8% of respondents who had experienced an improvement.
- The acupuncture brief pain inventory was also completed at discharge, along with the visual analogue scale. This enabled staff to understand if a patient had made appropriate progress during the ten sessions. Three patients who had completed the full ten-week cycle all indicated a reduction in their level of pain after treatment.
- The physiotherapy service provided a pelvic organ prolapse quality of life questionnaire to assess individual patient outcomes. We saw evidence of completed questionnaires in patient folders. A summary of patient progress following discharge was provided to the referring clinician.
- The physiotherapy manager chaired a regional acupuncture meeting with the other five hospitals in the northwest. This enabled the service to share information and good practice.

## Competent staff

- Staff had the skills, knowledge, and experience to deliver effective care and treatment. All new staff were required to undertake an induction training programme. A competency framework was in place and staff were expected to meet this. We viewed six staff training files all of which included competency records. All staff underwent a regular programme of mandatory training.
- The hospital had a continuing professional development (CPD) policy in place. The policy set out staff responsibilities to maintain an up to date CPD file. Funding existed for formal learning activities within the corporate and local training budgets and through the Ramsay Health Care UK Scholarship Fund. Staff could request training through the Ramsay Health Care UK Academy Prospectus.

- The senior physiotherapist had undertaken additional training in chronic pain management, and a counselling course to support patients with chronic pain.
- Staff in the department felt supported by their manager, and told us they could raise concerns with the manager at any time. There was variance in staff reporting that they had received formal one to one sessions with their manager. However, this seemed to be due to the small, close working nature of the department, and did not appear to have a negative impact on performance.
- Staff appraisals were carried out yearly between January and December. However, for year 2015, 14% of nursing staff received appraisals and no health care assistant staff received appraisals. The matron acknowledged this low rate, which was due to a number of issues. However, she said staff continued to receive informal support and advice from heads of department with any issues during the year, and confirmed that appraisals had restarted again for the current year.
- The head of department told us appraisals had recommenced in March 2016 and all staff were up to date with appraisals. Due to the small size of the department, regular formal one to one meetings were not scheduled with staff unless there were performance management concerns.
- Staff we spoke with in the outpatients, diagnostic imaging, physiotherapy, and administration teams confirmed they had received appraisals this year.
- All staff within the radiology department were registered with the Healthcare Professionals Council (HCPC)
- The hospital held records for all staff that had appropriate training to administer radiation. No untrained staff were employed. Competency records were also kept. These included competency to use each piece of equipment within the radiology treatment rooms and the movement of equipment within the rooms. Staff also attended a radiation protection update training course every two years.
- Consultants applying for practicing privileges were interviewed by the general manager and the matron, and had to supply copies of their training certificates. Additional checks were also made including identification, disclosure and barring service, review of references and evidence of indemnity insurance, and

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that the consultant was on the general medical council's specialist register. This information was signed off by the general manager and the medical advisory committee, before being confirmed by the Ramsay health care UK medical director. Practising privileges were reviewed every five years.

## Multidisciplinary working

- The nature of the outpatient and diagnostic imaging clinics and appointments meant there were limited opportunities for multidisciplinary working. However, physiotherapy staff were encouraged to attend appropriate outpatient consultant appointments. Staff told us of one such appointment where they were able to develop a physiotherapy plan for a patient with shoulder problems. This enabled staff to understand what was best for the patient, and meant it was also more convenient for the patient. Physiotherapy assistants also attended knee and hip pre-operation assessments to help the patient understand if there were any additional needs at home.
- Justification to carry out exposure to radiation for radiology images was provided as part of the referral process by the consultant who requested the image. Patients were also asked if they had had a radiological image taken within the previous six months and, if so, staff would request this from the previous organisation. Rules were in place for radiologists to justify images for some local procedures.
- Images were available to referring clinicians through the hospital's systems. This meant that plain X rays were available to view after the image was taken. The formal report was subsequently prepared by the radiologist; however, if there were any concerns that the images indicated abnormal results, initial findings would be reported to the clinician, and the patient's GP was made aware within 48 hours.

## Seven-day services

- The outpatients department offered a six day service, Monday to Saturday between 8.30am and 9pm. The late clinics provided flexibility for patients.
- The physiotherapy department offered evening acupuncture clinics on a Tuesday as the department was quiet.

- Routine diagnostic imaging services were carried out during weekdays between 8am and 8pm. The department provided an evening and weekend on-call service for emergencies in the wards. Additional scan lists were put on when needed if there was an increase in waiting times.

## Access to information

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- Discharge letters were sent to the patient's GP following completion of treatment.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- The hospital had a consent to treatment policy for competent adults and children/young people policy. The policy clearly set out that a person's capacity to consent to care and treatment was on a decision-specific basis. This meant that staff needed to consider a person's capacity to understand the information being given, ability to retain the information to make a decision, to use or weigh-up the information, and to be able to communicate their decision.
- There was a two-stage process to obtaining consent. Stage one was carried out by the consultant in the outpatient clinic, and included discussion of the benefits and risks of treatment. Information leaflets about the consent process, conditions, and treatments were available for patients. This meant that patients were able to make informed decisions about their

# Outpatients and diagnostic imaging

treatment. The second stage of consent was carried out on the day of treatment, and included confirmation that the risks of treatment had been discussed with the patient. Patients were given a copy of their signed consent.

- Although the consent policy was robust and in line with relevant guidance, the copy of the policy we reviewed expired in January 2016.
- The hospital carried out a consent audit every three months. The audit between September 2014 and June 2015 showed improvement in compliance from 94% up to 100%. A similar pattern was seen for September 2015 to March 2016 with compliance improving from 94% to 98%.
- The hospital also had a mental capacity policy and a deprivation of liberty safeguards policy in place. Consent and mental capacity was also part of the hospital's safeguarding adults at risk of abuse or neglect policy.
- Flowchart guidance on mental capacity was displayed within the department. Staff were aware of the policies and processes, but told us the majority of patients they treated had capacity to consent to their care. Staff were empowered to be able to stop a consultation or treatment if they had any concerns about a patient's ability to consent to treatment. The patient would then be assessed, with family members in attendance. If staff became aware that power of attorney was held by a family member, the patient was asked to return with their family.
- The hospital had a dementia screening tool. All patients over the age of 75 who were referred to the OPD were screened for dementia. Staff told us they will also ask younger patients to undergo screening if they suspect the patient may be showing signs of dementia.

Diagnostic imaging staff gave us an example of an elderly patient who was initially assessed as lacking capacity to complete an MRI safety questionnaire. Staff referred the patient back to the consultant who carried out and assessment and assisted the patient in completing the safety questionnaire.

## Evidence-based care and treatment

- Care and treatment was delivered in the department in line with legislation, standards and evidence based guidance.
- The hospital's policies and protocols were standardised at corporate level. They incorporated up to date recommendations and guidelines from the national institute for health and care excellence (NICE) and other professional bodies including the relevant Royal Colleges.
- Updated clinical guidance was reviewed at national level, and fed back to staff through the hospital's clinical governance and medical advisory committees.
- The pain management and acupuncture clinics were developed in line with the NICE guidance on the early management of lower back pain.
- Patient clinical pathways were also standardised. These took into account guidance and established practice. Specific pathway documents were used for each procedure.
- Diagnostic imaging procedures were carried out in line with established practice from the Royal College of Radiologists, the Ionising Radiation Medical Exposure Regulations 2000, and the Ionising Radiations Regulations 1999.
- Physiotherapy treatment was provided in line with established practice and guidance from the Chartered Society of Physiotherapy. Physiotherapy care and treatment was audited against the society's quality assurance standards audit tool.

## Pain relief

- The outpatient and physiotherapy departments used the corporate pain assessment tool and analgesia ladder to assess patients' pain, and to determine if any change to prescribed analgesia was needed.
- The physiotherapy department had developed and introduced a back pain management service and an acupuncture clinic. Three consultant pain specialists, one of whom was a consultant anaesthetist, and a consultant spinal surgeon, delivered the service. The physiotherapy and outpatient nursing team supported the medical team.

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- The pain service provided two types of injection treatments for back pain; injection into the weight bearing joints of the spine between two vertebrae, and nerve block injections under X-ray guidance.
- Outreach pain management clinics were provided in GP surgeries in the Skelmersdale, Formby and Wigan areas. This meant the service was able to see patients closer to their homes.
- The consultants and staff were aiming to develop the pain service further. There were physical limitations in the size of the available facilities; however, additional afternoon classes for knee pain were being considered to try to improve patient access to the service. The physiotherapy manager set up a hand physiotherapy group across all the Ramsay Health Care UK hospitals in the northwest.
- The acupuncture service used a brief pain inventory with patients on their first therapy session. This was a simple form to gauge a patient's level of pain.
- The inventory was supported by a visual analogue scale, where patients indicated each week an estimation of the level of pain they were experiencing at that time. This information was collated by the service over a twelve-month period, with a view to presenting learning from it to the team.
- The service aimed to introduce a monthly 'talk' for patients with chronic pain. This would discuss issues around how emotions and stress levels can influence levels of pain experienced.
- The acupuncture brief pain inventory was also completed at discharge, along with the visual analogue scale. This enabled staff to understand if a patient had made appropriate progress during the ten sessions. Three patients who had completed the full ten-week cycle all indicated a reduction in their level of pain after treatment.
- The physiotherapy service provided a pelvic organ prolapse quality of life questionnaire to assess individual patient outcomes. We saw evidence of completed questionnaires in patient folders. A summary of patient progress following discharge was provided to the referring clinician.
- The physiotherapy manager chaired a regional acupuncture meeting with the other five hospitals in the northwest. This enabled the service to share information and good practice.

## Competent staff

- Staff had the skills, knowledge, and experience to deliver effective care and treatment. All new staff were required to undertake an induction training programme. A competency framework was in place and staff were expected to meet this. We viewed six staff training files all of which included competency records. All staff underwent a regular programme of mandatory training.
- The hospital had a continuing professional development (CPD) policy in place. The policy set out staff responsibilities to maintain an up to date CPD file. Funding existed for formal learning activities within the corporate and local training budgets and through the Ramsay Health Care UK Scholarship Fund. Staff could request training through the Ramsay Health Care UK Academy Prospectus.
- The senior physiotherapist had undertaken additional training in chronic pain management, and a counselling course to support patients with chronic pain.
- Staff in the department felt supported by their manager, and told us they could raise concerns with the manager at any time. There was variance in staff reporting that they had received formal one to one sessions with their manager. However, this seemed to be due to the small, close working nature of the department, and did not appear to have a negative impact on performance.

## Patient outcomes

- The physiotherapy department recognised that measuring patient outcomes was an area that needed to be improved. Although physiotherapists recorded progress towards patient goals as one measurable outcome, the physiotherapy manager was in the process of trying to find an appropriate tool to measure patient outcomes going forward.
- However, the hospital's patient satisfaction survey for June 2016 showed that 100% of respondents who had received physiotherapy treatment said they had experienced an improvement in their condition. This was against a rolling quarter figure of 93.8% of respondents who had experienced an improvement.

# Outpatients and diagnostic imaging

- Staff appraisals were carried out yearly between January and December. However, for year 2015, 14% of nursing staff received appraisals and no health care assistant staff received appraisals. The matron acknowledged this low rate, which was due to a number of issues. However, she said staff continued to receive informal support and advice from heads of department with any issues during the year, and confirmed that appraisals had restarted again for the current year.
- The head of department told us appraisals had recommenced in March 2016 and all staff were up to date with appraisals. Due to the small size of the department, regular formal one to one meetings were not scheduled with staff unless there were performance management concerns.
- Staff we spoke with in the outpatients, diagnostic imaging, physiotherapy, and administration teams confirmed they had received appraisals this year.
- All staff within the radiology department were registered with the Healthcare Professionals Council (HCPC)
- The hospital held records for all staff that had appropriate training to administer radiation. No untrained staff were employed. Competency records were also kept. These included competency to use each piece of equipment within the radiology treatment rooms and the movement of equipment within the rooms. Staff also attended a radiation protection update training course every two years.
- Consultants applying for practicing privileges were interviewed by the general manager and the matron, and had to supply copies of their training certificates. Additional checks were also made including identification, disclosure and barring service, review of references and evidence of indemnity insurance, and that the consultant was on the general medical council's specialist register. This information was signed off by the general manager and the medical advisory committee, before being confirmed by the Ramsay health care UK medical director. Practicing privileges were reviewed every five years.

## Multidisciplinary working

- The nature of the outpatient and diagnostic imaging clinics and appointments meant there were limited opportunities for multidisciplinary working. However,

physiotherapy staff were encouraged to attend appropriate outpatient consultant appointments. Staff told us of one such appointment where they were able to develop a physiotherapy plan for a patient with shoulder problems. This enabled staff to understand what was best for the patient, and meant it was also more convenient for the patient. Physiotherapy assistants also attended knee and hip pre-operation assessments to help the patient understand if there were any additional needs at home.

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## Seven-day services

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## Are outpatients and diagnostic imaging services caring?

Good 

We rated Caring as 'Good' because: -

### Compassionate care

- People who used the outpatient and diagnostic imaging services were treated with kindness, dignity, respect, and compassion when they received treatment at the hospital. In June 2016, the patient satisfaction survey showed that 100% of respondents said they were treated with respect and dignity.
- We spoke with 21 patients during our visit, across all the OPD and radiology departments. All patients spoke positively about the staff and the care provided to them.
- One patient had concerns about the outcome of surgery; however, the patient still said 'all the staff are wonderful, everything was offered in a timely way'. Another patient told us 'all staff have been loving, very helpful'. A few patients told us that they 'could not fault' staff in the hospital.
- Staff in the physiotherapy department shared a compliment that had been received from a patient in 2015 which said the staff member was 'quite possibly the most professional, helpful individual I have ever had the pleasure to meet. She has helped me tremendously and is a real asset to your organisation'.
- We observed two patients who attended for X-ray. Staff greeted the patients appropriately, and introduced themselves by name. The patients were given the opportunity to ask questions. Although the patients were seen quickly, staff were respectful, polite, and professional in their manner throughout. We also observed staff talking to three patients in the physiotherapy department; gentle but clear explanations were provided by staff.
- The main reception area was at the entrance to the hospital, and co-located with the main waiting area for NHS patients. Staff were sensitive in conversations with patients, and were mainly involved with checking patients in for their procedures. We did not observe any confidential information being discussed at the reception desk. The physiotherapy and radiology waiting area was located next to the radiology reception window. We did not observe any confidential information being discussed with patients at this reception window.
- Each outpatient consultation room was private, and had an adjoining examination and treatment room. This meant that patients' privacy and dignity was maintained during OPD appointments.
- The physical layout of the physiotherapy department included three treatment bays in an open-plan room. This meant there was a risk that confidential information could be overheard when patients were receiving treatment in the bay areas. However, there were two separate treatment rooms available if patients had confidential information to discuss.
- A chaperone service was available to patients. Staff asked patients if they required a chaperone if they had

# Outpatients and diagnostic imaging

not indicated this on referral. Letters were sent to patients to make them aware of the chaperone service and reminder signs were clearly displayed in all consultation and treatment rooms.

## Understanding and involvement of patients and those close to them

- Staff in the department communicated with people about their care and treatment in a way they could understand. In June 2016, the patient satisfaction survey showed that 100% of respondents said that both doctors and nurses had explained the reasons for treatment in a way they could understand. In the same period, 98.4% of respondents said they were involved in decisions about their care.
- Radiographers ensured that patients understood instructions provided to them. When this was not possible, staff involved relatives or carers in the discussion; for example, when patients did not understand instructions for taking the oral contrast drink prior to scans.
- One patient told us her condition was clearly explained to her by her consultant. Subsequently, an anaesthetist took time to talk to her, to explain what would happen when treatment was provided, and gave her anti-sickness medication. The patient said 'it was such a good experience' and went on to describe staff as 'very professional, very welcoming, very calming'.
- Patients we spoke with told us they were aware of the next steps in their treatment, and that follow up appointments had been made quickly and within a reasonable timescale.
- We observed patients being prepared for outpatient treatment, and following treatment. Staff clearly explained the treatment to be undertaken, and information relating to discharge. Staff displayed caring and attentive attitudes throughout. One patient told us 'I can't fault them at all'. Two other patients confirmed that their procedure was clearly explained by the consultant prior to attending for treatment.

## Emotional support

- Some consultation rooms had an adjoining treatment room. This meant that privacy was maintained for patients who had received bad news.

- There were sufficient numbers of nursing and healthcare assistant staff on duty to be able to provide additional emotional support to patients, if needed, without affecting delivery of the service.
- The outpatients department had a range of patient information leaflets to give to patients. These clearly explained the patient's condition and treatment. These were provided during consultations and meant that patients were able to consider their options at home before making any decisions to proceed.
- One patient we spoke with, who was being treated for an eye condition, told us that staff were very caring. She said the consultant had carefully explained what would happen, and 'delivered what he said he would'. The patient was provided with good advice and a leaflet on side effects. The patient told us that she was cold while waiting and staff brought her a blanket. She told us staff reassured her that someone would stay with her while she was unable to see. The patient was allowed to stay in a room after treatment until a relative was able to pick her up.

## Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as 'good' because: -

### Service planning and delivery to meet the needs of local people

- The hospital actively monitored the uptake of available appointments through a weekly 'slot management' meeting. Referrals from GPs were reviewed on receipt and triaged for appropriateness and any concerns were fed back to the relevant GP.
- Any issues relating to under or over utilisation of appointment slots were discussed with individual consultants. This meant the hospital could adjust the number of appointments available to meet the demands on its services.
- The senior management team met with the clinical commission groups in contract and service development meetings. This enabled regular review of the services offered by the hospital, identification of

# Outpatients and diagnostic imaging

local health trends, market intelligence for the local communities, and introduction of new contractual obligations; for example the introduction of the pain management service.

- Waiting areas were clean and comfortable with adequate seating and televisions. Toilets and reading material were available in the reception area. General information leaflets relating to services provided, including complaints, were also available in the waiting areas.
- Free car parking was available on-site. During our inspection, the car park was nearing full capacity. The hospital recognised its limited parking facilities were an issue, particularly as there was no local public transport available near the hospital. However, the hospital was in the process of agreeing access to neighbouring land for staff parking which would relieve the car parking pressures.
- There was clear signage throughout the hospital to guide patients to the relevant outpatient, radiology, and physiotherapy departments. Reception staff directed patients to the appropriate waiting areas, where they were collected in turn by nursing or medical staff.
- The outpatients department provided a six-day clinic service, which included evening clinics up to 9pm. The main waiting area was within the reception area of the hospital. This meant that although there was no formal process in place, patients could leave the waiting area for a break without missing their appointment.
- The physiotherapy department offered clinics throughout the week, with some evening and weekend clinics in order to provide flexibility for patients. All initial patient appointments were for one hour, with follow-up appointments scheduled for 30 minutes.
- This included two knee physiotherapy classes per week. NHS patients were offered an initial one to-one assessment before attending a group physiotherapy class; other funded patients were provided with assessment and treatment on a fully one-to-one basis.
- A pelvic floor clinic for men and women was available with a maximum waiting time of two weeks for NHS patients. The department increased the number of clinics available in line with demand for the service.
- An acupuncture clinic was introduced in March 2016 and clinics were held on a Tuesday evening. The hospital had developed its own protocol for this clinic, with set criteria of the type of patient that could be referred to the clinic. There was a maximum two week

waiting time for the acupuncture clinic, and patients were offered ten sessions with strict adherence to appointments. The department told us that no patients had cancelled, or missed, appointments and that patients had ‘been very appreciative’.

## Access and flow

- Referrals into the OPD service were directly from GPs, consultants, and through the NHS choose and book appointment system. Patients who had other means of funding could self-refer into the physiotherapy service for priority appointments.
- The hospital had a waiting list and management of patients accessing NHS treatment policy in place. This set out key principles of how the hospital would manage patients who were waiting for treatment, with priority given to those with urgent clinical need. The principles incorporated the 18 week referral to consultant led treatment pathway (with diagnostic tests to be carried out within six weeks). The policy detailed when the ‘clock’ would stop and start, including for patients who did not attend their appointments.
- Between January and March 2016, 100% of non-admitted OPD patients started treatment within 18 weeks of referral. This exceeded the national target of 92%.
- No NHS patients were waiting longer than six weeks for magnetic resonance imaging scanning (MRI), computerised tomography CT, non-obstetric ultrasound, colonoscopy, flexible sigmoidoscopy and gastroscopy OPD diagnostic investigations between April 2015 and March 2016.
- Referrals to the OPD service for NHS patients were made through the “choose and book” system. A number of patients we talked to spoke positively about the waiting time to be seen in clinic. One patient told us that appointments had been quick, with a scan carried out within four weeks of the initial consultation, a follow-up appointment with the consultant two weeks later, and a plan was in place to carry out keyhole surgery within two weeks. The patient described the experience as ‘very timely from beginning to end’.
- Clinics ran to time during our visits to the hospital, and waiting times for patients after booking in at reception were minimal. Staff told us clinics would only run late if there was an emergency, or where a patient needed

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additional support after receiving bad news. However, patients waiting to be seen were kept informed by reception and/or nursing staff, and were offered refreshments if the waiting was expected to be lengthy.

- Patients we spoke with told us that tests, examinations, and follow-up appointments were scheduled quickly with minimal wait.
- Staff told us that patients rarely missed appointments particularly those who were not NHS patients. Following a missed appointment, the hospital sent an outcome letter to the patient requesting they re-book the appointment. If three consecutive appointments were missed, the consultant wrote to the patient's GP to inform them; a new referral was then required.
- Staff also told us that clinic cancellations were rare. In these circumstances, the appointments team contacted the patient to re-book the appointment. Patients were offered the choice to see a different consultant if this meant they could be seen earlier.
- The magnetic resonance imaging scanner (MRI) and the computerised tomography (CT) scanners could be booked for additional sessions if necessary to meet extra demand.

## Meeting people's individual needs

- The rural location and the demographic of the local population meant that the hospital did not have a large proportion of patients from black and ethnic minority population. Interpretation services were available through Language Line, and staff told us information leaflets were available in other languages if needed.
- Entrances to the hospital were accessible for people with mobility problems. Accessible toilets for patients living with a disability were located behind the reception area, and within the departments. The diagnostic imaging reception window was at standing eye level, which would be difficult for someone with mobility issues to access. However, staff told us most patients living with a disability were accompanied by an able bodied carer or relative who could access the reception window.
- The outpatients and diagnostic imaging departments were located on the ground floor of the hospital and were accessible for disabled patients. A lift was available to access the upper floor if needed.
- The hospital's patient satisfaction survey indicated that 100% of respondents said the physiotherapy team took into account any special needs they had.

- Due to the nature of the services provided within the outpatients and diagnostic imaging departments, staff told us they did not have large numbers of patients with learning disabilities or people living with dementia. Patients living with dementia were more prevalent in hip/knee and eye clinics. Three dementia friendly rooms were available within the day surgery unit. Dementia friendly clocks were located in waiting areas.
- The hospital carried out equality impact assessments and audited its facilities against the accessibility requirements of the disability discrimination act. As a result, the hospital ensured the toilet facilities within the outpatients department were disabled friendly, improved access for people with mobility issues at the entrance to the hospital, and parking facilities.
- For patients living with learning disabilities, staff involved carers and relatives in the consultations. Large print and easy read information was available
- Diagnostic imaging staff told us that patients with complex needs rarely visited the department. However, hoists, and wheelchairs were available to staff if needed.
- The hospital had developed a GP liaison manager role to establish good links between the hospital, local GPs, and the local care commissioning groups. The role included hosting a number of talks in conjunction with consultants from the hospital for patients in the community. These were designed to help patients self-manage. The hospital had scheduled outreach pain management clinics at a GP practice in Skelmersdale. This is an area of high deprivation and low car ownership.

## Learning from complaints and concerns

- The hospital had a 'management of patient complaints' policy in place and no complaints had been received about the OPD.
- Staff were given customer service training to assist them in dealing with complaints from patients. Staff told us they attempted to resolve verbal patient concerns at the time they were raised with staff. However, staff were aware of the hospital's complaint policy.
- In line with the complaints policy, the hospital acknowledged complaints relating to the department within two working days enclosing a copy of the complaints procedure information leaflet. Written responses were sent within 20 working days.
- The general manager was responsible for responding to complaints; however, investigation of the complaint was

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assigned to appropriate managers. Details of all complaints were logged on the hospitals incident reporting system; the complaint incident report was updated at regular intervals throughout the investigation. As part of the written response, complainants were invited to meet with the general manager if they were dissatisfied with the outcome. There was also a process in place for patients to escalate the complaint to regional and national level.

- Complaints were discussed at a range of governance meetings, including the heads of department meetings, medical advisory committee meetings, and northern matron's meetings. Learning was shared with staff in staff meetings
- Complaint outcomes were reviewed in monthly senior management meetings, heads of department meetings, and the medical advisory committee meetings. Learning from complaints was shared with staff via team meetings. Learning from systemic complaints was shared with all Ramsay health care UK organisations at a corporate level. Complainants who had exhausted the complaints process had the right to take their complaint to the health service ombudsman (for NHS patients) or to the Independent Sector Complaint Adjudications service (ISCAS – for patients who were self-funding)
- None of the patients we spoke with expressed any concerns or complaints about the care they had received from staff in the department.

strategy was being drafted to align with the business strategy. Both were supported by six 'Ramsay way values', and the 'six c's of nursing' (care, compassion, competence, communication, courage and commitment). The hospital also had a patient charter to ensure 'care [was] delivered in privacy, with compassion, dignity, and respect'.

- Although there was no separate strategy for the OPD, staff were aware of 'The Northern Blitz Spirit' strategy and the visual representation of the plan was displayed in the nurses' station. Operational staff were not able to explain the strategy in depth to us; however, they explained this was because it was relatively new for this business year. Staff told us that the strategy was regional with a view to all Ramsay health care UK hospitals in the region working to improve the care provided.

## Governance, risk management and quality measurement for this core service

- There was an effective governance framework in the hospital, which supported the delivery of good quality care in the department. The hospital was in the process of developing the range of data to be submitted to the private healthcare information network by September 2016.
- As part of the wider corporate organisation, the hospital had a clear governance and committee structure in place including clinical governance, medical advisory, and health and safety committees. The governance structure was supported by detailed policies and procedures.
- Staff were clear about their roles, how they fitted within the hospital structure, and who held the relevant lines of reporting responsibility.
- Senior management meetings were held monthly. These reviewed new legislation, corporate policies, and guidelines. Complaints, significant events, and lessons learned were also discussed.
- Clinical governance meetings were held quarterly, which were attended by all heads of department. Standing agenda items discussed included: review of key clinical indicators, corporate audits carried out, complaints, adverse incidents, transfusion issues, and infection control. The meeting also discussed updates to guidelines, processes, and clinical practice.

## Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as 'good' because: -

### Vision and strategy for this core service

- The hospital had a new business strategy for 2016 to 2017, called 'The Northern Blitz Spirit', people were placed at the heart of the strategy, which focused on effective engagement with patients, staff, consultants, and stakeholders in order to understand and respond to the needs of the local health care economy.
- The strategy aimed to ensure robust and comprehensive governance arrangements were in place, including processes, people and planning, in order to provide effective services to patients. A clinical



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- Operational managers meetings were held monthly. These meetings discussed a number of items including significant events and complaints, incidents, specialism monthly performance reports and risks.
- A full programme of audits was in place across the outpatient and diagnostic imaging departments. Although it was not always possible for us to disaggregate audit data specifically for the outpatients department, the results of audits were discussed at the various committees and any risks arising from these were fed into the relevant risk register. However, there was limited data collected in outpatients, physiotherapy and diagnostic imaging to measure patient outcomes and performance.
- The hospital had a risk assessment policy in place. The policy detailed responsibilities for each member of staff, and set out the actions to be taken to assess risk, to record and to score risk assessments.
- There was a corporate risk register and risk registers for each clinical area. Risk management was an agenda item on the health and safety committee however as the MAC chair did not sit on the health and safety committee there was no clear clinical ownership of risk.
- A risk register for the OPD was in place. This identified 24 minor or insignificant ongoing risks; each had a review date in place. However, the register did not provide a detailed description of each risk or the actions that had been taken to mitigate them. This meant the register did not provide assurances that the risks, albeit minor, were being appropriately managed.
- Medical advisory committee (MAC) meetings were held every three months. Standing agenda items included: review of the general hospital update; review of the clinical governance report and complaints; the MAC chair's report, the sign-off for use of any unlicensed medication, and credentialing of new consultants. As part of this, arrangements were in place by the MAC for checking and confirming consultant's indemnity insurance in line with legislation, the consultant's qualifications, and registrations.
- The hospital was completing the workforce race equality standard (WRES) reporting template.
- In line with the Ramsay health care UK Values, the hospital managers promoted a 'no blame' culture. This was supported by staff who told us they felt supported by their teams, their heads of department, the matron, and the senior management team. The matron visited each department daily.
- A number of staff within the department had long-standing service within the hospital. In discussion three staff members told us they felt respected and welcomed, liked coming to work and that there was an open and honest culture in the hospital.
- The head of department told us that although there was a disparity in staff wages with the NHS, the hospital had good staff retention due to the culture. She told us one staff member, who left to join the NHS, had since returned to the hospital as a result.
- Staff in the diagnostic imaging department told us the heads of department were very responsive to staff concerns; they openly discussed and addressed issues. Staff felt there was a good working relationship with the matron, and communication with the corporate central communications team had improved.
- Diagnostic imaging staff told us increasing numbers of patients were being referred to the service, but there were physical limitations on expansion of the service at the hospital. However, staff spoke positively about the working environment. This included the flexibility and friendliness of colleagues, and there were good opportunities for development and training through the Ramsay health care UK Academy.
- The hospital had a lone working policy. An emergency buzzer was available in clinics for staff working alone. New patients were not booked into a clinic where staff were alone, and careful consideration was given to booking male patients with female staff.

## Public and staff engagement

- The hospital gathered feedback from staff through a staff survey in 2016. Called the 'my voice survey', 85% of staff felt engaged with the hospital as their employer, which was better than the average for Ramsay health care UK. 85% of staff were satisfied with their work, while 84% were happy with their working environment. An average of 92% felt the hospital was focused on patients and customers.
- A high number of staff indicated they had not experienced bullying, and a lower number believed the hospital promoted a healthy work/life balance. 85% of

## Leadership / culture of service

- Staff spoke positively about the overall leadership team, including the general manager, matron and heads of department. The out-patients head of department told us 'we work together as one big team'.

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staff were satisfied with their level of health and wellbeing overall. 90% of staff believed communication and collaboration was good within their teams and in support from line managers. However, there was only 75% satisfaction with the senior management team.

- The hospital gathered feedback from patients in a number of ways. The 'we value your opinion' leaflet (which also provided details of how to complain); through the hospital's patient satisfaction survey results; and from the NHS friends and family test (which asks patients to rate how likely they would be to recommend the service to their friends and family).
- For the period July 2015 to June 2016, the hospital's patient satisfaction survey indicated that between 94% and 100% of people were satisfied with their overall experience in the hospital.
- For the period of October 2015 to March 2016, the hospital achieved a 100% score for NHS funded patients. This was for a response rate of between 55% and 96%, and was higher than England average throughout the same reporting period.
- Friends and family test scores for April 2016 showed that 97% of NHS patients would recommend the department. This was based on a 15% response from 3091 eligible patients. For individual specialities within the department, ENT (ear, nose and throat) had the lowest score of 93%, while neurosurgery, ophthalmology, plastic surgery, radiology and urology all scored 100%.

- Diagnostic imaging staff reported they had received 100% on both the patient satisfaction and the friends and family test. Positive comments had also been left on the NHS Choices website by patients.
- The hospital group monitored and reported on compliance with the equalities Act 2010 in relation to employed staff. Ramsay health care UK developed objectives to address equality issues that had arisen in the report.
- The hospital had a staff development funding policy in place. Referred to as the 'Ramsay scholarship fund', this enabled staff to apply for financial support through the Ramsay Health Care UK Scholarship for courses costing more than £500. Staff were permitted up to three days' paid leave per year for study or examinations relating to course undertaken through the scholarship fund.
- The hospital had a disclosure of information (whistle-blower) policy. This which set out the procedures to follow with internal disclosures and with disclosures to regulatory bodies.
- Staff were positively engaged with the hospital, and in their roles. One staff member told us they were 'very proud to work for Renacres'; another staff member told us they were proud of their team and said that all staff in the hospital 'get on well'.

## Innovation, improvement and sustainability

- The acupuncture clinic, run by the physiotherapy department, was developed and introduced in March 2016 to treat patients with lower back pain.
- Outreach pain management clinics were developed and implanted in local GP surgeries in Skelmersdale.

# Outstanding practice and areas for improvement

## Outstanding practice

In the outpatients department:

- NHS patients received treatment in a timely manner following an initial referral, with follow-up appointments scheduled in appropriate timescales.

Between January and March 2016, 100% of non-admitted OPD patients started treatment within 18 weeks of referral. This exceeded the national target of 92%.

## Areas for improvement

### Action the provider SHOULD take to improve

### Action the hospital SHOULD take to improve

- The hospital should improve appraisal rates
- Review the skill mix of the hospital staff and delegate appropriate tasks to lower banded staff following training and competency assessment.
- Update the consent policy.
- Put the corporate risk register as a standing agenda item on the clinical governance committee meeting so that there is clinical ownership of the risk register through the MAC chair.
- Make the corporate risk register more local so that risks that did not impact on the hospital or where the risk was very low were removed from the register.

- Make the risk registers live documents, with more frequent reviews and actions and to develop risk management structures across the hospital and to link them into the clinical governance agenda.

In the outpatients and diagnostic imaging departments the hospital should:

- Consider how it can improve the inclusion of corrective actions following audits within the audit records, and how it can clarify within the results which area or department of the hospital the audit related to.
- Consider how it can ensure that diagnostic imaging equipment is replaced, when appropriate, in a timely way.