Winfield Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Winfield Hospital as part of our programme of comprehensive inspections of acute independent health hospitals. We visited the hospital on 9 and 10 of August and carried out an unannounced inspection on 18 August 2016.

We rated the hospital as requires improvement overall, with both surgery and outpatients and diagnostic imaging rated as requires improvement.

Are services safe at this hospital?

- Following a never event, duty of candour had not been applied in a timely manner and we were not assured the process was fully embedded.
- Staff were trained to the appropriate level of safeguarding and were able to describe the process for reporting a concern.
- The hospital had a good safety culture, where staff were encouraged to report incidents. However, staff were not trained in root cause analysis investigation.
- Some staff in theatres were not up to date with infection control training. Actions were in place to address this, with additional time allocated.
- There were arrangements for transferring patients for emergency care. The hospital had a service level agreement with the nearby NHS acute hospital.
- There were not robust systems in place to track medicines and prescription pads in the outpatients department.
- Staffing needs and patient acuity on the ward were assessed up to a week in advance and the off duty was adjusted to reflect this. We saw that staff were flexible to help cover shifts. Staffing levels on the ward and in theatres were adjusted to the needs of the service and during a day of increased activity more staff would be asked to work the shift. The hospital used minimal agency and bank staffing and were actively recruiting during the time of the inspection
- Consultants worked at the hospital under practising privileges and were supported by a resident medical officer who covered the service at all times.

Are services effective at this hospital?

- Patients had good outcomes from hip and knee replacement surgery and the hospital was benchmarked against other Ramsay hospitals.
- In line with the NHS Institute for Innovation and Improvement guidance, the hospital used the enhanced recovery programme (ERP) for patients who underwent orthopaedic surgery. This care pathway was designed to encourage a quicker recovery following major surgery and a shorter hospital stay.
- The medical advisory committee oversaw and approved practising privileges at each meeting ensuring medical staff had appropriate skills and experience of the procedures they wanted to undertake.
- The recording of appraisals did not always reflect the scope of practice the surgeon carried out at the hospital.
- There was good multidisciplinary working and staff were positive about the 'daily huddles', where key updates were communicated.
- An audit undertaken of screening in theatre had shown a reduced radiation dose when screening was undertaken by radiographers and this was now standard practice.

Summary of findings

- Nursing staff had a clear understanding of what consent was and when it was required. All staff we spoke with had awareness of the Mental Capacity Act 2005 and could explain what a best interest decision involved.

Are services caring at this hospital?

- In the first quarter of 2016 satisfaction survey results showed that between 99% and 100% of NHS day case, inpatient and private patients would recommend the service.
- Patients and their relatives were kept informed and involved in decisions about their care and treatment. We spoke with one patient who stated that staff had been caring and thoughtful towards their relative.
- Patients attending the diagnostic imaging department, who were required to undress, were not offered sufficient privacy while waiting for their treatment. However, plans were in place to reconfigure the department to address this.

Are services responsive at this hospital?

- The needs of different patients were considered in the planning and delivery of the service.
- Services were planned to meet patients' needs. The hospital had worked with the local clinical commissioning group to identify the needs of patients who were waiting for cardiology diagnostic investigations.
- Both NHS and private patients told us that they did not have to wait a long time for an appointment to see a consultant and that the most suitable admission dates had been discussed and agreed with them, before being finalised. The hospital consistently met the NHS standard which measures the time that people wait from referral by their GP to consultant-led treatment.
- If patients were identified as having complex needs, staff told us that any issues were discussed with patients' families to determine whether additional support or adjustments were needed.
- People who complained were offered meetings, where appropriate. We saw that responses to complaints contained an apology and there was evidence that the concerns raised had been fully investigated. Information on how to make a complaint was not well publicised in outpatients.

Are services well led at this hospital?

- Clinical incidents were reviewed by the hospital's clinical governance committee and medical advisory committee. Standard agenda items for these meetings reflected this.
- Minutes of the clinical governance committee and senior management team meetings did not record sufficient detail of discussion of all agenda items. This did not provide a robust audit trail and evidence that the planned agenda items and risks were regularly reviewed.
- Minutes of the MAC meetings recorded poor attendance with, in the main, a core of consultants regularly attending. This did not reflect the hospital policy that all consultants should attend the MAC as part of being granted practising privileges at the hospital.
- Staff told us the registered manager and matron were visible and accessible and had an 'open door' policy.
- Results of the most recent staff survey showed low scores for communication and feeling valued by the corporate group and that local leaders did not take the views of staff seriously. The senior management team was working on a new staff engagement strategy, responding to the themes highlighted in the staff survey.

Our key findings were as follows:

Summary of findings

- There had been changes to the management at the hospital which had led to a review of the services by the provider. The resulting action plan had identified a range of issues to be addressed and the registered manager and clinical leads were working on improvements.
- The registered manager was visible and had a plan to relocate their office so as to be more easily accessible to staff.
- In the outpatients department there had been a difficult transition period while a new radiology manager managers settled in there had been no permanent outpatients manager for some months. Staff meetings did not occur regularly and some staff consequently felt they did not a have a voice.
- The recent staff survey had yielded a disappointing response and highlighted some worrying themes. Staff engagement and involvement needed to improve to address issues which affected staff morale and make them feel more valued.
- 'Daily huddles' had been introduced to help inter-departmental working and heads of department were engaged in team building and looking at ways to better support each other and
- work cohesively. Staff told us that the huddles provided a good mechanism for communication across the hospital departments.
- All areas we visited were visibly clean and staff demonstrated the processes in place for cleaning.Oversight and monitoring of cleaning standards was not recorded or fed back to staff in charge of departments.
- Not all patient records we viewed were accurate, comprehensive, legible or contemporaneous. We were concerned about the systems for taking and storing photographs for those patients undergoing cosmetic surgery.
- We observed good practice among theatre teams when using the World Health Organisation (WHO) five steps to safer surgery safety checklist in the operating theatres. We observed conversations around patient consent, the surgical site was marked, and risks of venous thromboembolism (blood clots) had been anticipated. Staff were all present for completion of the whole checklist.
- The hospital strategy identified that patient satisfaction results, environmental and clinical audits should be discussed at team meetings. Patient satisfaction was identified as a standard agenda item on the clinical governance committee minutes but in minutes we reviewed there was no information or evidence of discussion at the meetings.
- There was evidence of learning and improvement following two incidents in diagnostic imaging and an incident in the physiotherapy department.
- In a patient satisfaction survey in outpatients in May 2016: 100% of respondents said they were involved in decisions about their care and treatment and 100% said the staff told them how they would find out their test results.
- There was insufficient evidence that managers had oversight of all performance, including risks to quality and safety. The recent provider visit had highlighted weakness in governance processes which still needed to be improved. For example, there was insufficient oversight of mandatory staff training and little evidence that audits were consistently taking place as planned or learning was taking place following these audits.
- The hospital had recently appointed to the post of clinical quality lead to monitor and oversee of the clinical audit programme and ensure action plans from departments were progressed. Additional audits could be added if required. This was a developing role and it was planned to encompass oversight of complaints, clinical audit and patient satisfaction

There are areas where the provider needs to make improvements.

Summary of findings

Importantly, the provider must:

- Ensure that all medicines held within the diagnostic imaging department, are stored correctly, in accordance with manufacturers' guidance.
- Ensure there are robust systems in place to track medicines and prescription pads in outpatients in order to prevent theft or misuse.
- Take action to ensure that patient records are legible accurate, comprehensive and contemporaneous and completed by all members of the multidisciplinary team.
- Ensure that consent for medical photography is obtained and clearly documented in the patient record. Ensure that medical photographs are stored safely and securely in line with policy
- Ensure compliance to the surgical safety checklist and audit appropriately to provide assurances
- Ensure that the duty of candour is implemented in a timely manner for those incidents where regulation 20 applies.
- The provider must ensure that audits provide the evidence that the governance systems are effective.
- Ensure that all equipment such as commodes are properly decontaminated.
- Ensure systems are in place to maintain an overview of the compliance data with cleaning standards.
- Ensure that reporting and assurance from audits completed on the ward and in theatres provide the evidence that the governance systems are effective.

  Ensure meetings follow the corporate standard agenda and that all items are discussed and recorded with sufficient detail to provide assurance and actions

In addition, the provider should:

- Consider the removal of carpets in patients' rooms to ensure adequate cleaning.
- Consider remedial improvements to the walls in the dirty utility room.
- Ensure better attendance at medical advisory committee meetings.
- Ensure that staff consistently receive feedback about adverse incidents to ensure learning and improvement.
- Proceed with planned replacement of the imaging table with a height-adjustable table to reduce the risk of falls and staff injury.
- Take steps to support people in vulnerable circumstances, such as patients living with dementia or patients with a learning disability.
- Review patient information leaflets and ensure that information is made available in languages other than English and other formats, such as large print, braille or easy read.
- Take steps to better publicise the complaints system to patients, inform patients of sources of support with their complaint and reassure them that their care and treatment will not be affected by the fact that they have made a complaint.
- Proceed with planned works to improve the privacy and dignity of patients who are required to undress in the diagnostic imaging department.
- Ensure management oversight of mandatory training compliance and take steps to improve compliance.

Summary of findings

- Continue to develop staff engagement, explore reasons for poor staff survey results and take actions to address these.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	We rated surgery services overall as requires improvement because: • The WHO surgical safety checklists were not fully completed. This was indicative of a lack of engagement from some of the senior members of the surgical team. • There was poor implementation of the duty of candour after a never event. • There had been a delay in reporting and investigating a serious incident in theatres regarding the use of the wrong consent form. • There was a lack of detailed documented discussions around incidents and risk and other standard agenda items in committee meeting notes. • The audit programme lacked consistency and was not being used effectively. • There was poor documentation of care and treatment by some consultants. • We were not assured that all the relevant information needed to deliver effective care and treatment such as clinical guidelines and audit compliance were discussed at senior level. • There was inconsistent practice in the taking of consent for medical photography for patients undergoing cosmetic procedures. • Staff satisfaction survey results were low. However, • The hospital delivered good surgical outcomes to patients. There was a good multidisciplinary approach to care and treatment this was reflected in hospital outcomes and the Enhanced Recovery Programme. • The hospital used minimal agency and bank staffing and were actively recruiting during the time of the inspection • In 2014 theatres endoscopy service had gained accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

Summary of findings

- There was evidence of learning about the duty of candour after the never event.
- The hospital responded with a robust action plan when issues were raised about storage and consent of medical photography.
- We saw evidence of contingency planning. The matron and the ward manager had planned for any anticipated staffing shortfall.
- Waiting times, cancellations and delays were minimal and managed appropriately.

Outpatients and diagnostic imaging

Requires improvement

We have rated outpatients and diagnostic imaging as requires improvement overall because:

- Staff did not always receive feedback following adverse incidents.
- Medicines were stored in the diagnostic imaging department at temperatures which were above recommended levels.
- There were inadequate systems in place to track medicines and prescription pads in outpatients in order to prevent theft or misuse.
- The imaging table in the X-ray room was not height- adjustable. Staff had to use portable steps to assist post-operative patients on to the table, posing the risk of injury to staff and patients.
- The provider was unable to provide us with accurate and up-to-date information in respect of staff compliance with mandatory training. We could not therefore be assured that staff had the required knowledge of safety systems, processes and practices. Staff in outpatients and physiotherapy were not up-to-date with role-specific competencies.
- The hospital had taken few steps to support people in vulnerable circumstances, such as patients living with dementia or patients with a learning disability. Staff in outpatients were not able to describe any examples of support which may be provided to such patients.
- Patient information leaflets relating to surgical procedures did not indicate that they could be made available in languages other than English or other formats, such as large

Summary of findings

print, braille or easy read. Staff told us they had never been asked for information in other formats and they were not aware of any facility to provide this.

- Information on how to access the complaints system was not well publicised and patients were not offered support with their complaint.
- Patients attending the diagnostic imaging department, who were required to undress, were not offered sufficient privacy while waiting for their treatment.
- Governance and reporting processes were not fully effective to ensure effective communication 'from ward to board' and 'from board to ward'.
- There was insufficient evidence that managers had oversight of all performance, including risks to quality and safety. The recent provider visit had highlighted weakness in governance processes which still needed to be improved. For example, there was insufficient oversight of mandatory staff training and little evidence that audits were consistently taking place as planned or learning was taking place following these audits.
- The management team had suffered from a period of instability with a significant number of management changes. There had been a difficult transition period while managers settled in. Staff meetings did not occur regularly and some staff consequently felt they did not a have a voice.
- The recent staff survey had a disappointing response and highlighted some worrying themes. Staff engagement and involvement needed to improve to address issues which affected staff morale and make them feel more valued.

However,

- Staff understood their responsibilities to report incidents and were encouraged to do so.
- Risks to patients were assessed and their safety was monitored and maintained.

Summary of findings

- There was evidence of learning and improvement following two incidents in diagnostic imaging and an incident in the physiotherapy department.
- Departments were mostly clean and tidy. Staff observed standard infection control precautions and disposed of waste appropriately.
- Premises and equipment were designed and maintained to keep people safe.
- Staff treated people with compassion, kindness, dignity and respect.
- We observed staff interact with patients in a respectful and considerate manner.
- Patient satisfaction survey results showed consistently high levels of satisfaction.
- Staff took steps to ensure that patients' privacy and dignity were protected, including during physical and intimate examinations and treatment.
- Patients were involved as partners in their care. Patient satisfaction survey results showed that patients were well informed about their care and treatment and knew how and when they would receive test results.
- Patients received timely access to care and treatment. The hospital consistently met the NHS standard which measures the time that people wait from referral by their GP to consultant-led treatment.
- Outpatients' clinics took place so that, as far as possible, patients were able to access care and treatment a time that suited them. Clinics mostly ran to time so that people were not inconvenienced and cancellations rarely occurred.
- Premises were mostly appropriate for the services that were planned and delivered. There was ample free car parking, good signage and waiting areas were light, airy and comfortable.
- The hospital had a clear strategy and had developed a vision statement with involvement and engagement from staff. Not

Summary of findings

all staff felt engaged in this and not all staff could articulate the vision statement but they all expressed with passion their desire to provide the best patient-centred care.

- The senior management team was now established and from October 2016, all heads off department posts would be filled.
- The senior management team were respected; in recent months they had become more visible and most staff told us they were accessible and supportive.
- The senior management team were working on a new staff engagement strategy, responding to the themes highlighted in the staff survey. Daily huddles had been introduced to help inter-departmental working and heads of department were engaged in team building and looking at ways to better support each other and work cohesively.
- Most staff told us they enjoyed working at Winfield Hospital. Teamwork and camaraderie were cited by many as being the best thing about working there.
- The hospital had recently appointed a quality lead who would have oversight of the clinical audit programme.

Summary of findings

Contents

Requires improvement

Winfield Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Winfield Hospital

Winfield Hospital is part of the Ramsay Healthcare group and provides surgery and outpatient services for NHS, self-funding and private patients. The hospital is situated on the outskirts of the city of Gloucester and the majority of patients live in the city and local area.

There are 35 beds on one ward, three operating theatres and an outpatient department. Services provided include general surgery, gastroenterology, spinal surgery, urological and gynaecological surgery, orthopaedic surgery (such as total hip and knee replacement), ear, nose and throat, oral and maxilla-facial, cosmetic and plastic surgery. Patients are treated on a day case basis or are accommodated on the ward.

Outpatient services provide consultant-led clinics in a range of specialities, including orthopaedics, general surgery, ENT, maxillofacial, ophthalmology, dermatology, gynaecology, cosmetics and urology. There are also nurse-led pre admission clinics and general nurse appointments for services such as removing dressings, sutures and plasters. There are 11 consulting rooms and two treatment rooms.

Diagnostic imaging services provided include plain X-ray, fluoroscopy and ultrasound. There is a mobile image intensifier and a mobile x-ray unit. There are also mobile services provided by Ramsay UK Diagnostics twice weekly for magnetic resonance imaging (MRI) and once a fortnight for computed tomography (CT).

Physiotherapy services are provided to outpatients and inpatients. Facilities include a fully equipped gymnasium with an anti-gravity treadmill and treatment rooms. Services include hydrotherapy, treatment of sports injuries, ultraviolet treatments, musculoskeletal assessment and treatment, post-operative rehabilitation, pilates classes and a 'back school'.

Our inspection team

Our inspection team was led by:

Inspection Lead: Tracey Halladay, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a theatre nurse, outpatient services manager, consultant surgeon.

How we carried out this inspection

Prior to the inspection we reviewed a range of information sent by the provider this included data, policies, complaints, investigations and minutes of meetings. We spoke with the clinical commissioning group and local Healthwatch to gain feedback on their view of the hospital.

During the inspection we spoke to a wide range of staff both clinical and non clinical, this was at focus groups and also during our time spent in the ward and in departments.

We inspected both the surgery and outpatient and diagnostic imaging services. The registered manager had been in post for less than a year having worked and managed other hospitals within the Ramsey Health group for a number of years.

Patient feedback came from comment cards which were available on the ward and at the outpatient reception, this enables us to gather feedback prior to the inspection. We also spoke with patients and their relatives on the ward and those attending the outpatient department.

We visited the hospital on 9 and 10 August and carried out an unannounced visit on 18 August 2016.

Summary of this inspection

Information about Winfield Hospital

During the reporting period (April 2015 to March 2016), there were 5,118 inpatient and day case episodes of care.

54% of patients were NHS funded patients and 46% were privately funded either by medical insurance or on a self-pay basis.

Surgery was carried out on patients 16 years and above until April 2016 when patients under the age of 18 were no longer admitted.

There were 30,101 outpatient total attendances in the reporting period April 2015 to March 2016.

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? Start here...	**Requires improvement** 
Are services effective? Start here...	**Good** 
Are services caring? Start here...	**Good** 
Are services responsive? Start here...	**Requires improvement** 
Are services well-led? Start here...	**Requires improvement** 

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Requires improvement

Surgery

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

Information about the service

Winfield Hospital offers a range of NHS and private elective surgical procedures for a range of specialities. This includes general surgery, gastroenterology, spinal surgery, urological and gynaecological surgery, orthopaedic surgery (such as total hip and knee replacement), ear, nose and throat, oral and maxilla-facial, cosmetic and plastic surgery. Patients are treated on a day case basis or are accommodated on a 39-bedded ward. Consultants lead the service, supported by operating theatre teams and ward based nursing teams.

The hospital has three operating theatres, which are equipped with laminar flow air filtration systems (designed to reduce the risk of airborne contamination) and a Joint Advisory Group (JAG) accredited endoscopy unit. Theatres operate Monday to Friday from 8am to 7pm and one theatre operates on Saturday from 8am to 4pm. The endoscopy unit has its own recovery area and carries out colorectal surgical procedures Monday to Friday 8am to 6pm.

During the reporting period (April 2015 to March 2016), there were 5,118 inpatient and day case episodes of care. 54% of patients were NHS funded patients and 46% were privately funded either by medical insurance or on a self-pay basis. Surgery was carried out on patients 16 years and above until April 2016 when patients under the age of 18 were no longer admitted.

We visited the operating theatres, the endoscopy suite, theatre sterile services unit and the inpatient ward. We spoke with members of the staffing team including, nurses, consultants and pharmacists. We spoke with patients and some of their relative's pre and post operatively.

Summary of findings

We rated surgery services overall as requires improvement because:

- The WHO surgical safety checklists were not always fully completed. This was indicative of a lack of engagement from some of the senior members of the surgical team.
- There was poor implementation of the duty of candour after a never event.
- There had been a delay in reporting and investigating a serious incident in theatres regarding the use of the wrong consent form.
- There was a lack of detailed documented discussions around incidents and risk in committee meeting notes.
- The audit programme lacked consistency and was not being used effectively.
- There was poor documentation of care and treatment by some consultants.
- We were not assured that all the relevant information needed to deliver effective care and treatment such as clinical guidelines and audit compliance were discussed at senior level.
- There was inconsistent practice in the taking of consent for medical photography for patients undergoing cosmetic procedures.
- Staff satisfaction survey results were low.

However

Requires improvement

Surgery

- The hospital delivered good surgical outcomes to patients. There was a good multidisciplinary approach to care and treatment this was reflected in hospital outcomes and the Enhanced Recovery Programme.
- In 2014 theatres endoscopy service had gained accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).
- There was evidence of learning about the duty of candour after the never event.
- The hospital responded with a robust action plan when issues were raised about storage and consent of medical photography.
- We saw evidence of contingency planning. The matron and the ward manager had planned for the anticipated staffing shortfall.
- The hospital used minimal agency and bank staffing and were actively recruiting during the time of the inspection.
- Waiting times, cancellations and delays were minimal and managed appropriately.

Are surgery services safe?

Requires improvement

We rated surgical services as requires improvement because:

- There was a lack of engagement by some staff to the surgical safety checklist which had resulted in a never event. However we observed good practice among theatre teams when using the WHO checklist in the operating theatres.
- Senior staff responsible for investigating serious incidents had not received training in root cause analysis.
- There had been a delay in reporting and investigating a serious incident in theatres regarding the use of the wrong consent form.
- There was a lack of detailed documented discussions around incidents and risk in committee meeting notes.
- We were not confident that staff were fully aware of when the duty of candour should be applied in relation to serious incidents.
- There was limited use of the safety thermometer and information about patient harm was not displayed for patients and staff to see.
- There was poor monitoring of compliance with infection prevention and control procedures for hand hygiene and environmental cleanliness.
- There was inconsistent practice in obtaining consent for medical photography for patients undergoing cosmetic procedures and no evidence of a cooling off period being offered when patients consented for a cosmetic procedure.
- There was unsafe storage of medical photographs of patients undergoing cosmetic procedures.
- We reviewed 10 sets of records and found they were not accurate, comprehensive, legible or contemporaneous and records of all interactions with the patient were not documented.
- We could not be assured that surgeons were always available for their patients and could access the hospital within a 30 minute time frame.

However

- Electrical equipment on the ward and in theatres was maintained to keep people safe.
- The ward, with exception of the dirty utility room, was clean and tidy and well maintained.
- Medicines were managed in a way which kept patients safe from harm.

Incidents

- Staff we spoke with on the ward and in theatres were aware of their responsibilities when reporting incidents and risks. Staff had access to computers to report incidents on an electronic reporting system. There were 144 clinical incidents reported in the reporting period of April 2015 to March 2016, 36% of these occurred in surgery or inpatients. There were 36 non-clinical incidents of which none occurred in surgery.
- Staff told us incidents classified as moderate or above were reported to the corporate risk lead and senior staff completed a root cause analysis when necessary. No formal training on root cause analysis had been completed by these staff members, although training dates had been arranged for September 2016.
- Senior staff told us that clinical incidents were reviewed by the hospital's clinical governance committee and medical advisory committee (MAC). Standard agenda items for these meetings reflected this; however, there was a lack of detail recorded to show what issues were discussed.
- Learning from incidents was cascaded to the ward teams via a newsletter. We saw how this was used to remind staff not to send patients to theatre without all the appropriate risk assessments completed. Staff who had read the newsletters signed to say they had done so, we reviewed several newsletters and saw multiple staff signatures. Staff told us that this was an easily accessible way for them to gain information about recent incidents and risks. The daily huddle meetings were also used to cascade information about incidents and risks to staff across all departments.

Duty of Candour

- Staff were familiar with the Duty of Candor regulation, but had varying degrees of understanding of when it would be applied. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014 and April 2015 for independent providers. This Regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Senior members of staff told us there was a culture of openness in response to incidents but did not differentiate between lower grade incidents and those requiring application of duty of candour. There was a Ramsay Being Open Policy, which was also displayed for staff to see in the staff canteen.
- However, there was a delay of 13 days in correctly implementing the duty of candour following a never event which occurred during January 2016.

Never events and serious untoward events

- Serious incidents and never events were reported to corporate leads, including the chief executive, the clinical commissioning group (CCG) and the nominated individual. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at national level.
- A never event was reported in January 2016 which related to wrong side surgery on an elective surgical patient. A root cause analysis completed following the never event identified that a number of factors led to the event including that, there was a negative attitude towards the World Health Organisation (WHO) Surgical Safety Checklist, 5 steps to safer surgery. The WHO checklist is an internationally recognised system of checks designed to prevent avoidable harm during surgical procedures. The patient did not have their side marked prior to leaving the ward, theatre staff did not complete the WHO surgical safety verbal checklist and staff did not respond to verbal concerns raised during the operation. There was a culture in which staff felt unable to speak up to consultants or senior staff when they felt something was wrong.
- A thorough review was undertaken and the root-cause analysis provided clear details of the event. The incident was discussed at the Medical Advisory Committee (MAC) and Clinical Governance Committee. An action plan was developed to reduce the risk of this happening again. In response to the learning from this incident a number of new Ramsay corporate policy standard operating procedures (SOPs) were developed. These included, a list safety officer and a safety briefing and debriefing SOP, a site marking SOP, which was aimed at ward staff

as well as theatre staff, a 'stop before you block' SOP and a surgical safety procedure list debriefing form. The clinical governance committee were in the process of ratifying these at the time of our inspection.

- The new processes were included in Ramsay's clinical audit programme, due to start in September 2016 across all Ramsay locations. Individual departments were on a three-month rolling audit programme and we were assured that the frequency of audits could be increased if the need arose. The never event happened in January 2016 and during theatre departmental meeting minutes it was documented that further observations of WHO check lists were to be carried out. The frequency of surgical safety audits was not increased, but audits were completed within the normal three month rolling programme.
- The never event report identified that communication with the patient, their family and their GP during surgery and discharge was inadequate. The duty of candour disclosure did not take place until 13 days after the incident occurred; this was not as soon as was reasonably practicable.
- Consultants were informed of the never event and we saw documented discussions in the senior management team, theatre department, medical advisory and clinical governance meetings minutes.
- There were two serious incidents (SI) reported, one during the reporting period (April 2015 to March 2016), which related to the use of an out of date prosthesis. The report into this incident showed confusion over who was responsible for certain areas of the prosthesis checking process. Once this was identified clear accountability and responsibility for the process was assigned to staff members and this involved stock level and expiry date checks and reordering.
- The second SI where a patient was admitted to theatre and underwent a surgical procedure with the wrong consent form, was under investigation at the time of our inspection, and had been since June 2016. Initial investigations attributed the incident to human factors, poor adherence to policy and procedures and poor compliance to safety measures (WHO). Human factors refer to environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety
- In this instance, the duty of candour was applied effectively and immediately showing, clear learning from the never event in January 2016.
- Further training had been carried out for senior members of staff and a training programme was in place for September 2016. This training programme would include the implementation of the new SOPs and embedding them into practice, looking at how to deal with human factors and local training scenarios. Ramsay Health was also implementing at the time of our inspection, webinar sessions aimed at theatres, outpatient department and radiology staff.

Safety thermometer

- The ward collected monthly data for the NHS safety thermometer and provided it to the hospital matron. The NHS safety thermometer is a collection of data submitted by all hospitals treating NHS inpatients. The data collected was a snapshot of inpatients suffering avoidable harm, usually on one day each month. TheNHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers**,** falls**,**urine infections (in patients with acatheter) and venous thromboembolism (VTE).
- Staff were unclear what happened to the data after it was collated and this information was not displayed for the staff or the public to see, as is considered best practice. The results were publically available on the Health and Social Care Information website.
- The National Institute for Health and Care Excellence (NICE) guidance recommends that all inpatients are assessed for the risk of developing VTE. The hospital reported variable compliance with this standard. In the period April to June 2015 the hospital achieved 90%. In the following two quarters compliance improved, achieving 97% but screening rates for January to March 2016 could not be calculated due to inadequate data, no reason for this was provided.
- VTE assessments were checked on the ward and again in the anaesthetic room. We reviewed ten sets of patients' records and saw that assessments had been completed and prophylactic treatment prescribed if required
- We were assured that patients would not be sent to theatres without a completed VTE assessment. A senior member of staff had recently requested a surgeon to

return to the ward to complete the assessment, prior to the patient leaving the ward for theatre. The consultant responded to this request and completed the assessment.
- There were two reported incidents of hospital acquired VTE during the period from April 2015 to March 2016.

Cleanliness, infection control and hygiene

- There had been no incidences of methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile or of e-coli bacterial infections in the reporting period (April 2015 to March 2016). There had been no reported incidences of surgical site infections.
- There were carpets in some of the private patient bedrooms. The carpets looked clean and free from stains; they were in good order and had no visible damage but this made it difficult to push beds and was considered an infection control and manual handling risk. We were told this had been put on the risk register but there were no plans for them to be changed. As identified in Health building guidance notes (HBN) in order to facilitate cleanliness and cleaning flooring should be impervious, smooth and seamless and where possible hard flooring should be run up the walls for a short distance. The cleaners told us carpets were steam cleaned every month and every six months a deep clean of the carpets took place but we saw no documentary evidence of this, therefore we could not be assured practices were monitored sufficiently.
- The dirty utility area on the ward was in need of maintenance as it had chunks of plaster knocked out of the wall. Adequate cleaning of the dirty utility area could not be assured. Bags of dirty uncontaminated linen and bags of rubbish were left on the floor. The commode that was stored in the dirty utility had patches of rust and was not labelled as clean. When we tipped the commode over to check the underneath water drained out on to the floor from the inside of the chair. We were assured however that the ward manager had ordered new commodes and they were awaiting their delivery.
- The housekeeping supervisor and head of operations undertook monthly environmental cleanliness audits and fed back any issues to heads of department. The overall score and compliance data was not routinely fed back to the lead of the department therefore there was no overview of compliance with cleaning standards.
- The endoscopy and theatre sterile services unit (TSSU) had identified some issues in a very recent audit carried out by the national decontamination lead for Ramsay Health. Endoscopy was scored as 75% compliant and TSSU as 54% compliant. Issues identified included not checking the compatibility of the endoscope with the disinfectant and not completing risk assessments for aspects of decontamination of re-useable medical devices such as the use of chemicals spillage. These non-conformities were uploaded onto the hospitals quality management system via corrective action preventative action (CAPA) forms. There were clear actions identified in the audit data and this was witnessed in meeting minutes from the infection prevention and control committee. A re-audit date was confirmed for November after the Inspection date.
- All the staff we observed working on the wards and in theatres were compliant with infection prevention and control principles of hand washing. Hand washing sinks, hand gels, and personal protective equipment were readily available. We observed staff washing their hands and using personal protective equipment when required. All the patients we spoke with told us all the nurses washed and gelled their hands
- We observed most staff following infection control principles of bare below the elbows and no nail varnish or jewellery; however, several ward staff wore their hair below their collars.
- We were not assured that infection control practices were monitored sufficiently. Hand hygiene audits had been carried out once since December 2015 but the audit data supplied did not always contain dates of when they were carried out by or on whom. We saw no further formal audits but notes from April's 2016 infection prevention and control committee meeting minutes identified that hand hygiene scores had dropped to 50%. A brief action plan had been identified but no re-audit date was documented in the meeting notes.
- The infection prevention lead organised all ward and theatre in-house training for infection control, including hand hygiene and skin surveillance. However, department heads were responsible for releasing staff to attend training. We saw from mandatory training records that some theatre staff had not been updated since 2013 and 2014. However this had been responded to through the infection control lead increasing their

hours from 15 hours per month to 20 hours per month to support departments in audit compliance. A back to basics hand hygiene day had also been arranged for September 2016, alongside an e-learning programme.

- The hospital infection prevention and control standards were not always met for those patients who required a cannula (vascular access device) for administering intravenous fluids and medications. During an audit in September 2015, 10% of procedures were carried out without an aseptic technique, and 60% of procedures were poorly documented in the notes. The next audit took place in May 2016, however it did show a significant improvement with scores of 100% for aseptic technique and 80% for documentation of procedure.
- We saw evidence of up-to-date daily and weekly cleaning task lists with clear identification of who was responsible for each task on each shift. We reviewed 32 weeks of weekly task lists and only 24 were fully completed; however, daily and monthly task lists were completed and fully signed.
- There were equipment cleaning schedules in place and we saw that staff had completed checklists for equipment cleaning in theatres. Equipment on the ward looked visibly clean and in a good state of repair. All items were labelled and dated to show when they had been cleaned.
- The hospital participated in Public Health England Surveillance and Patient Led Assessment of the Care Environment and scored 89% for cleanliness, this was below the England average of 98%.
- Theatre areas inspected were visibly clean and free from dust and debris. Theatres were cleaned in the evenings by three housekeeping staff who had a very basic cleaning manual. Staff told us that this was being updated and a new manual was being printed. This would include more specific information about how to clean and what cleaning materials to use. This was not yet in place. We reviewed weekly and daily cleaning task lists in all theatre areas and all were completed and signed.
- Ward areas we inspected were clean and free from dust and we saw teams of cleaning staff working together to clean hard to reach/high level areas of the ward. Bedding and linen were visibly clean and we reviewed the mattress audit folder, which showed a clear email trail for replacement mattresses.
- Water systems were serviced annually by an external company and temperature and legionella checked carried out weekly.
- Sharps boxes in theatres and on the ward were assembled and signed correctly, and not overfilled.

Environment and equipment

- Electrical equipment on the wards and in theatres was maintained to keep people safe.
- The hospital had its own team of engineers for all daily maintenance tasks. The operations manager oversaw all of the equipment checking and compliance levels. All equipment that we checked in the theatres and ward areas were labelled with appropriate stickers to indicate recent electrical testing and recent servicing.
- We reviewed the records for the hospitals generator testing and saw fully completed annual checks and monthly in house testing.
- We reviewed the records for the uninterrupted power supply and saw fully completed annual checks and weekly theatre checks.
- There was appropriate resuscitation equipment throughout the hospital for use in an emergency. The resuscitation equipment and trolleys on the ward and in theatres were visibly clean and free from dust. The top of the trolleys were checked daily and the entire trolleys checked weekly. All records of these checks having been carried out were complete and all trolleys were sealed and tagged to show they had not been tampered with since this check.
- We were assured that the arrangements for managing waste and clinical specimens in theatres kept people safe. We saw that specimens were stored within a cold room in theatres. The hospital had a contract with a local trust for the investigation of these specimens and there was clear documented register of when specimens were signed in and out.
- Surgical instruments were stored and transported through the departments safely. The theatre department operated an electronic track and trace system to reduce any risk of used equipment being misplaced. All equipment, once cleaned was dispatched with a clear record of its destination completed.
- The majority of the ward area was clean and tidy and patient rooms we observed were in a good condition. All the bathrooms we observed were clean and had no visible areas of wear and tear.

- Inpatient feedback from July to August 2016 was all positive. Comments included:
  - "Accommodation was pleasant and clean".
  - "The hospital was pristine and a pleasure to be in".
  - "Cleaning was excellent".
  - "My room and all the ones I visited were exemplary".
  - "The environment was safe and hygienic."
  - "All aspects of my room were spotless".
  - "The room was clean, functional and had adequate storage".
- The hospital participated in Public Health England Surveillance and Patient Led Assessment of the Care Environment (PLACE). Scores were below average for appearance and maintenance of the ward however we saw evidence in the meeting minutes of the Medical Advisory Committee (MAC) that low PLACE scores were being addressed with a refurbishment programme.

Medicines

- Medicine cupboards and treatment rooms in all areas were kept locked and medicines were stored safely.
- The ward treatment/drug room fridge and fridges in theatres all had daily recorded temperature checks documented and showed that temperatures were consistently within an acceptable range, (between 2*C and 8*C). There were clear instructions for staff in the event that temperatures were not in range. All medicines, such as insulin, were stored correctly in a fridge and were all in date.
- Controlled drugs (CDs) were mostly ordered, stored and recorded in accordance with the Misuse of Drugs Act 1971 and associated regulations. CD registers were checked in theatres and on the ward; however, there were occasional gaps in the theatres register where staff had not signed. The pharmacy department audited the CDs once every three months and any issues were raised with the chief pharmacist. Theatres and the ward areas had suitable cupboards to store their CDs and both departments used a signed log to monitor which staff member was in charge of the CD keys during that shift. However, we saw some missing signatures in the ward log. We saw the appropriate documentation of a CD disposal on the ward on a patient controlled analgesia chart. CD audits scored consistently above 95% and no common themes were identified.
- We were told that medicine reconciliation was completed within 24 hours when patients were admitted to the hospital, Monday to Friday only. Medicines reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines. The National Institute for Health and Care Excellence (NICE) recommends that all patients have this completed within 24 hours of admission to make sure the correct medicines are prescribed.
- The medication safety thermometer was being used at the hospital. The medication safety thermometer is a measurement tool for improvement that focuses on medication reconciliation, allergy status, medication omission, and Identifying harm from high risk. No data was available as this had only recently been introduced.
- We reviewed five prescription charts and all were signed, dated and fully legible. Any medicines omitted had a documented reason in the notes and, where appropriate, a VTE prophylaxis was prescribed.
- The pharmacy operated Monday to Friday and did not have an out of hours' service. If medicines, with the exception of CDs, were required out of hours, the staff nurse and resident medical officer would sign drugs out of pharmacy together.
- Medication incidents were managed appropriately and the pharmacist or ward staff would report through the incident reporting system. Incidents and actions would then be discussed at the two monthly pharmacy meetings and the chief pharmacist would send out learning outcomes. Latest NICE guidelines were also discussed (once alerted through an electronic system). However, the pharmacy manager raised concerns over the safety of prescribing VTE prophylaxis. We were told that there was no single policy for prescribing VTE prophylaxis and some consultants had a different approach to others. The pharmacy manager had raised concerns over the lack of uniformity and the risk it could pose to safety.

Records

- We reviewed 10 sets of inpatients' records. Six sets were fully completed with signed and dated entries to document conversations with consultants. However, we saw evidence of very poor documentation from some surgeons. This was not in keeping with the Royal College of Surgeons (RCS) Good Surgical Practice.
- Four patient records we reviewed were not accurate, comprehensive, legible or contemporaneous and records of all interactions with the patient were not documented. In one patient's operation notes there was

no date, no anaesthetic record or anaesthetist was documented and the operation notes were illegible. There was no written evidence the patient had been seen post operatively by the surgeon for two days, although the patient assured us they had. In another patient's record, we found the surgeon's previous day's operating list with other patient's personal details. This contravened the General Medical Councils (GMC) record keeping standards and was raised with the ward manager on the day of the inspection. Again, there was no documented evidence the patient had been seen post operatively, even though the patient assured us they had. In the same set of notes we found no evidence of a cooling off period being offered for cosmetic procedures, which, according to the Professional Standards for Cosmetic Standards must be given to the patient. There was no documentary evidence that the patient had been given the time and information they needed to reach a voluntary and informed decision about whether to go ahead with the intervention.

- One patient we spoke with confirmed they had had medical photographs taken prior to the procedure but there were no photographs or documented consent in the patient's notes.
- There was a lack of consistency in relation to documenting consent for, and storage of, medical photography. This was discussed with the senior management team during our inspection and immediate action was taken to address this. They told us that, from that point onwards, only one consent form would be used. A camera was ordered specifically for this use and stored in the out patients department. Consultants were instructed not to use their own personal devices for taking photographs. The medical photography policy was in the process of being reviewed. We saw emails from the MAC chair and the medical director to consultants to inform them of this requirement.
- The pre-operative assessments that we reviewed were well documented, completed and acted upon. Patients coming to the hospital for a procedure completed a pre-operative questionnaire. Patients would be given advice and guidance about any medicines they were regularly taking (warfarin, for example) that needed to be stopped before their admission.
- All patient notes were kept securely in a filing cabinet in the nurses' office and were out of sight of patients and visitors. The office was lockable when needed.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse and staff were aware of their duties to report abuse or suspicions of abuse. No safeguarding concerns were reported to the CQC in the reporting period (April 2015 to March 2016).
- The matron was the hospital's appointed lead for safeguarding and staff knew whom to contact if the matron was not available.
- The hospital did not provide us with a departmental breakdown of information regarding e-learning adult and children safeguarding training. We were provided with a core mandatory training matrix which told us that only a third of qualified nurses, operating department practitioners and clinical support workers had completed the e learning safeguarding of adults .The same staff groups had all completed the safeguarding children e learning element. The hospital provided us with details of the face to face safeguarding training for adults and children. Adult safeguarding training was 93% for ward staff and 29% for theatre staff. Children safeguarding training was 100 % for both departments. We saw that 100% of staff who required safeguarding children level three had completed it.

Mandatory training

- Not all the staff were up-to-date with their mandatory training and the information supplied by the hospital did not give us an overall percentage of completion of face-to-face and e- learning training.
- Mandatory training included basic life support, intermediate life support training, infection control, hand hygiene training, and manual handling. Examples of areas, which had not completed full compliance, were hand hygiene training which was at 63% compliance. The ward manager had a plan to address this and aimed to do hand hygiene back to basic training in September 2016.
- The ward leaders were aware of who needed what training and displayed spread sheets in the ward office highlighting this. This was easily accessible for all staff to see. This identified nine staff members' mental health training was out of date and six staff needed blood transfusion training.
- Senior members of the ward team had provided recent face-to-face training on recognising and treating sepsis. There were posters with key learning points displayed.

Senior members of the ward team who had completed advanced life support (ALS) training would be setting up a cohort of staff that could deliver advanced training on the ward. This would be commenced in October 2016.
- Theatre staff had a dedicated mental health practice facilitator; however their training was out of date.

Assessing and responding to patient risk

- The hospital used a Modified Early Warning System (MEWS) to identify the deteriorating patient. Staff we spoke to on the ward and in theatres all stated that if a patient triggered above a certain level on MEWS the nurse in charge and the resident medical officer (RMO) would be informed. Our observations confirmed this as we saw the nurse in charge of the ward appropriately escalate a patient to the RMO.
- There were arrangements for transferring patients for emergency care. The hospital had a service level agreement with the nearby NHS acute hospital. If a patient significantly deteriorated during any stage of their treatment then they would be transferred to the local emergency department by NHS ambulance.
- Theatre staff followed the 'five steps to safer surgery'. This involved following the World Health Organisation (WHO) surgical safety checklist. The WHO surgical safety checklist aims to decrease errors and adverse events, and increase teamwork and communication in surgery. The checklist formed part of a procedure carried out to scrutinise all safety elements of a patient's operation. This included, checking the correct patient, the correct operating site, consent had been given, and all the staff were clear in their roles and responsibilities. The WHO checklist contains core content but could be adapted locally or for specific specialties through the usual clinical governance procedures. After the completion of a root cause analysis for the never event and two serious untoward incidents it was clear to the hospital that certain problems existed with compliance in areas of the WHO checklist and checking of prosthesis. Common themes could be clearly identified and the hospital were taking steps to address these. New standard operating policies (SOPS) were in the process of being implemented and new procedures and staff roles were developed to assure the safe checking of prosthesis. It was identified that further audit should be carried out on surgical safety but we were not provided with any further audits other than the hospital standard three-monthly audits.
- However, when we reviewed 10 sets of post-operative patients' records we saw good paper recorded compliance with the WHO checklist, showing clear learning and an improvement in safety standards.
- We observed good practice among theatre teams when using the WHO checklist in the operating theatres. There were good observed conversations around patient consent, the surgical site was marked, and risks of venous thromboembolism (blood clots) had been anticipated. Staff were all present for completion of the whole checklist.
- The ward used a sepsis pathway to help in the identification and escalation of sepsis. Staff received training on the pathway on a one to one basis and it was incorporated into the advanced life support sessions. A cohort of senior staff had been educated to deliver specific training sessions in sepsis and these sessions were due to start in the following months after the inspection.
- We were not provided with any information regarding massive haemorrhage protocols or training scenarios.
- The on call rota was clearly displayed in the ward and theatres offices. When consultants were not available to be call out of hours for their patients then, they had to provide suitable alternative surgical cover, ensuring all relevant staff at the hospital and their patients were aware of the cover arrangements in place.
- Anaesthetists were responsible for their patients for a minimum of 24 hours post operatively and were required to be readily available and easily contactable by the hospital staff. If a problem occurred after 24 hours post procedure the first point of call would be the anaesthetist involved in the case. If they were not available, there was an arrangement with a group of anaesthetists, which provided on call cover.
- The patient journey policy outlined site specific variations for example cosmetic patients may need a more thorough psychological assessment in line with RCS professional standards for cosmetic practice. However the records did not show any documented discussions around this issue.

Nursing staffing

- Several experienced staff members had recently left their positions in the hospital. Several members of staff assured us that these were for unrelated reasons. Only one exit interview had been carried out. Some of the staff who had left had done so due to retirement.

- Ward staff told us how the loss of experienced members of the nursing team had made recent work load and covering shifts difficult, however they told us that when necessary the senior ward nurses would cover shifts, rather than use agency nurses, or when agency or bank staff were unavailable.
- We saw evidence of contingency planning. The matron and the ward manager had discussed the anticipated staffing shortfall and theatre lists had been adjusted accordingly. The impact of this on patients was not identified. Theatre staff were relocated when required, other hospitals had been emailed to ask for help and the matron would help to co-ordinate the ward in a supernumerary role when required.
- Staffing needs and acuity were assessed up to a week in advance and the rota was adjusted to reflect this. We saw that staff were flexible to help cover shifts. Staffing levels on the ward and in theatres were adjusted to the needs of the service and during a day of increased activity more staff would be asked to work the shift, or different shift times may be offered to cover busier times of the day. Regular overtime was offered and when we asked staff about these different shift times, they proved to be quite popular.
- However, some staff identified that when the hospital was quiet and they did not need to work they could end up owing time. This resulted in working longer days and some staff felt that there was no process in terms of the hours they owed.
- The ward planned to start using the Shelford Safer Nursing Care Tool. This is an evidence-based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms.
- The ward was staffed safely and the ward manager would staff the shifts appropriately and flexibly according to need. During the reporting period vacancy rates in theatres were around average when compared to other similar acute hospitals, there were no vacancy rates for operating department practitioners (ODPs) or health care assistants (HCA's) . Vacancy rates for registered nurses on the wards was higher than the average when compared to similar acute independent hospitals but was there was no vacancies for HCA's
- The ward was actively recruiting at the time of the inspection and was employing agency staff to cover staffing shortfalls when possible. Agency staff were block booked where possible to improve continuity. The ward manager told us that an extra health care assistant would be deployed when possible, to support the agency nurse if required. All agency nurses were given a ward induction and we were shown the folder which contained copies of signed documents demonstrating that agency nurses had read the care pathway summary, signed the confidentiality agreement, completed the checklist for orientation and completed a drug administration assessment.
- During the reporting period (April 2015 to March 2016) trained nursing bank and agency usage for inpatient areas and theatre areas was below the average of other independent acute hospitals. There was no healthcare agency workers employed on the wards during the reporting period and variable use of bank and agency for theatre ODP's and HCA's. Handovers took place at the start of every shift on the ward. We observed a morning handover from the night staff to the morning staff and this was safe, confidential and comprehensive. Staff discussed patient's allergies, relevant medical history and any medications such as analgesia they were given overnight.
- There was an on call rota for theatre staff. Three staff were on call overnight and if they were called out then they did not work the next day. The ward had informal on call arrangements, whereby a senior staff member was available to provide guidance and advice if required.

Surgical staffing

- There were 160 doctors and dentists employed at the hospital with practising privileges. Practising privileges were granted by the medical advisory committee following a rigorous process. This involved an interview with the general manager, checks on qualification, health, professional skills, competence and professional registration, medical indemnity and disclosure and barring service (DBS).
- One RMO covered the service at all times and was supplied from a pool of staff provided by an agency. The agency provided evidence of pre-employment training before the arrival of each RMO. The matron told us that this was also reviewed and signed off by the medical advisory committee (MAC) chair.
- The RMO that covered the service at the time of the inspection was not qualified to the higher specialty training level 3 (ST3). The Royal College of Surgeons

(RCS) recommends in their publication Emergency surgery 2011, in case of emergency return to theatre an ST3 or someone with Membership of the Royal College of Surgeons (MRCS) and Advanced Trauma Life Support, (ATLS) must be able to see urgent patients within 30 minutes. This meant that, in the absence of a suitable qualified RMO the consultant was the overall person in charge of care would be required to see patients within 30 minutes. However, we could not be assured that all consultants could access the hospital within a 30 minutes time frame.

- Surgeons were responsible for their own patients and in accordance with their practising privileges and Ramsay Health Care's Facility Rules surgeons needed to be readily available and easily contactable by the hospital staff. If they were not available, they had to provide suitable alternative surgical cover, ensuring all relevant staff at the hospital and their patients were aware of the cover arrangements in place.
- The medical agency, called the RMO daily to check what hours they had worked, that they had been engaged with patients and staff, and what disturbances they had overnight. If it was identified that the RMO had been working over 10 hour days then the agency provided a standby RMO to take over and allow the RMO a 24 hour break. We asked the RMO if this happened and we were given an example when a standby RMO had been sent to take over for 24 hours.
- The consultant for each patient was the overall person in charge of their care and undertook all post treatment reviews. The RMO told us that consultants would hand over any concerns that they may have for a patient and actions associated with those concerns, such as repeat blood tests. The RMO told us that support from the consultants and anaesthetists was very good, and there were never any issues if a consultant needed to be called out of hours.

Major incident awareness and training

- The business continuity plan was due for review during the month of our inspection. The plan aimed to counteract interruptions caused by disasters and security failures and was a policy which was applicable to all Ramsay Health Care UK staff.
- We asked staff what actions they would take during a major incident and staff could tell us there were protocols and that they had training on what to do in the event of a fire. In the event of any other major incidents, they told us they would escalate to senior staff and await instructions.
- We were not provided with any information regarding massive haemorrhage protocols or training scenarios.

Are surgery services effective?

Good

We rated the effectiveness of surgery as good overall because:

- We saw good evidence of how the orthopaedic enhanced recovery programme was being delivered by the multidisciplinary team.
- NHS and private patients had good outcomes from hip and knee replacements.
- Patients' post-operative pain, nutrition and hydration was monitored and managed effectively.
- There was a strong commitment to staff training and a robust induction programme for substantive and agency staff.
- We found that staff worked effectively together to deliver safe care and treatment.
- Readmission rates and unplanned transfers were similar in comparison to other similar hospitals.
- The hospital had good access to out of hours cover.

However

- We were not assured that all the relevant information needed to deliver effective care and treatment was available to staff.
- The recording of appraisals did not always reflect the scope of practice the surgeon carried out at the hospital.
- We could not be assured that during the pre-admission consultation of patients undergoing cosmetic surgery included a thorough psychological assessment.

Evidence-based care and treatment

- We saw how the pre-admission services were carried out in line with hospital policy and National Institute for Health and Care Excellence (NICE) guidelines (NG 45). The relevant investigations were requested in relation to co-morbidities such as diabetes and respiratory problems. Patients' lifestyles were assessed and the

appropriate information and advice was given in relation to health factors such as giving up smoking. All clinical risk assessments were undertaken and we were assured that if any risk factors needed escalating they would be done so.

- In line with the NICE innovation and Improvement guidance, the hospital used the enhanced recovery programme (ERP) for patients who underwent orthopaedic surgery. This approach was designed to encourage a quicker recovery following major surgery and a shorter hospital stay. This was standard practice for both NHS and private patients, undergoing major orthopaedic surgery. Patients were encouraged to eat, mobilise and return to their normal activities of daily living as soon as possible.
- The hospital physiotherapist saw all patients either on the day of surgery or after surgery and patients were assisted out of bed and commenced their physiotherapy and exercises in line with the ERP. A patient told us, "Physios had a good understanding of the process and what needed to happen to accelerate recovery".
- In 2014 theatres endoscopy service had gained Joint Advisory Group (JAG) accreditation for Gastrointestinal Endoscopy .JAG was established in 1994 to provide UK wide support for endoscopy services to ensure they have the skills, resources and motivation necessary to provide the highest quality, timely, patient-centred care.
- The hospital told us that they benchmark their services against other Ramsay sites. The national clinical governance committee reviewed all key performance indicators.
- The theatre department were updating their standard operating procedures (SOPs) in line with the World Health Organisation's 5 steps to safer surgery. This was in response to a never event and two serious incidents. The new SOPs were being implemented into practice in line with the model for improvement in the National Patient Safety Agency' How to Guide' for Five Steps to safer Surgery.
- The hospital used the Modified Early warning Score (MEWS) as a surveillance method to track all patients clinical conditions. This alerted the clinical team to any deterioration therefore triggering a timely response, we observed the appropriate escalation of a patient who had scored outside of the safe scoring of the MEWS.
- Anaesthetic assessment was carried in line with the American Society of Anaesthesiologists (ASA).We saw documented evidence of ASA scores in the patient record.
- During the inspection period the hospital recorded breast implants on their own register but had submitted an application form to the National Breast and Implant Register in line with professional guidance. We could not be assured that during the pre-admission consultation of patients undergoing cosmetic surgery included a thorough psychological assessment in line with the Royal College of Surgeons recommended standards and guidance.

Pain relief

- Post operative patients we spoke with reported seeing the anaesthetist in the pre-operative clinic. They told us discussions about pain relief and assurances that everything would be done on the ward to control pain were carried out.
- The patient satisfaction survey asked if 'staff did everything to control pain' and the results we reviewed scored positively with between 94 and 100% of patients in agreement from March to May 2016.
- There was no dedicated pain team in the hospital; anaesthetists were responsible for managing patient's pain in theatres and recovery.
- Pain assessments were carried out throughout the patient's stay and we observed staff assessing patients' pain levels on the ward and offering analgesia when pain was reported.
- We observed the ward handover from the night staff to the day staff, and patients' pain control was discussed. Staff reported what analgesia their patients had been given overnight and if they had been effective.
- Patients told us "my pain medication was dealt with immediately as needed" and "staff were helpful, caring, and monitored pain levels well and responded quickly as pain escalated". One patient we spoke with told us they had a lot of pain post operatively but that it was constantly assessed by the nurses and the pain relief they were given was effective. Another patient we spoke with told us that when they were in pain they were offered analgesia immediately and the nursing staff gave a detailed explanation about what medication was being offered.

Nutrition and hydration

- Patients were assessed for risks of poor nutrition or hydration by the use of the Malnutrition Universal Screening Tool (MUST). We saw documented evidence of this assessment taking place.
- Patients who were given intravenous fluids had their fluid intake and output documented to maintain a correct fluid balance total.
- Prior to their admission all patients we spoke with had been given clear explanations and instructions as to when they should stop eating and drinking. Every patient we spoke with had not been starved or gone without fluids for an inappropriately excessive amount of time in line with hospital policy and RCoA 2014 guidelines.

Patient outcomes

- Ramsay Health Care's national clinical performance committee reviewed the key performance indicators across the whole of the organisation and the hospital benchmarked itself against other Ramsay hospitals
- The hospital recorded breast implants in its own register but had submitted an application to the National Breast and Implant Register. The hospital sent data to the National Joint Registry (NJR) and Patient Related Outcome Measures (PROMS) audits for NHS-funded patients undergoing hip and knee replacement and groin hernia surgery.
- PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients. The hospitals adjusted average health gain for PROMs Hip, knee and groin hernia were all within the expected range.
- There were 13 cases of unplanned transfers of patients to other hospitals. This represented 0.25% of the total number of patients treated at the hospital. There were six cases of patient readmissions within 28 days of their discharge. This represented 0.1% of total inpatient and day case admissions. These scores were similar in comparison with other independent acute hospitals.
- There were 11 cases of unplanned returns to theatres between April 2015 and March 2016. We asked for the breakdown of this data but only received the data from August 2015 to February 2016, which detailed four incidents. No common theme could be identified.
- Ramsay Health Care UK is a member of private Healthcare Information Network (PHIN).
- The hospital did not provide information about participating in the Anaesthesia Clinical Services Accreditation Scheme (ACSA).
- The hospital did not provide us with any information that routine collection of Q-PROMs for cosmetic surgery was collected.

Competent staff

- There were 160 consultants employed under a practising privileges agreement. Practising privileges were granted to medical practitioners by the hospital governing board subject to them providing certain evidence of their good character, qualifications, skills and experience and compliance with the terms and conditions of the practising privileges policy.
- Six consultants had their practising privileges removed due to retirement, relocation and voluntary termination of contract during the reporting period of April 2015 to March 2016.
- We reviewed five surgeons' records and found all disclosure and barring service (DBS), references, professional registration, occupational health, speciality qualifications were checked and up to date.
- However, the recording of appraisals did not always reflect the scope of practice the surgeon carried out at the hospital. One file contained the photo of a front sheet of an appraisal only which had been sent electronically and then printed out. We discussed some of our concerns with the documentation of practising privileges and were told that due to a change in hospital management the practising privileges policy and procedures were in the process of being updated.
- All appraisals for nursing staff were up to date on the ward. The hospital did not record appraisals electronically but we saw the paper documents of ward staffs appraisals with objectives clearly identified. Theatre staff told us that their appraisals were not up to date due to a recent staffing change, but we were not supplied with any data to establish what proportion of staff had been appraised.
- We saw a ward health care assistant 'new starter booklet'. This comprehensive booklet included two weekly reviews, a three-month review and then a

six-month appraisal. All two weekly reviews and the three-month review had been documented and there were useful links to policies and a 'jargon buster' crib sheet.
- Staff told us that they felt the hospital invested well in staff training and we were told of an arrangement that the hospital had with the local trust whereby staff could participate in a three-day placement in a local intensive care unit, with the aim of improving their skills in the recognition of the deteriorating patient.
- Clinical supervision for ward staff was being implemented at the time of our inspection. This aimed to discuss management of certain situations and scenarios, such as the deteriorating patient, patient phone call and post- operative enquiries using recent examples and analysing staff actions.

Multidisciplinary working

- Staff, teams and services worked together to deliver effective care and treatment. We saw evidence of effective patient handovers between nursing staff and other departments and discussions around pain relief, mobility and discharge arrangements. There was good evidence of internal multidisciplinary (MDT) team working between nursing staff and the physiotherapy department. The patient pathways documented clearly physiotherapy input and a clear plan.
- We were told and we saw that the consultants handed over any relevant information to the resident medical officer (RMO) before leaving the hospital. We were told the RMO contacted the consultant surgeons and anaesthetists at home if they needed to and found them easy to contact.
- A daily huddle had been introduced several months prior to our inspection. This took place every morning and a member of each department attended and then fed back to their ward or department. When we spoke with staff they all told us they thought the daily huddle worked well and was often a forum to discuss incidents, issues and staffing for that day.
- There was an arrangement for anaesthetic cover from a pool of anaesthetists employed by the local NHS trust. The rota for this cover was clearly displayed in theatres and in the ward office and all the staff knew where to access the information.
- The hospital sent a GP summary discharge letter following each patient episode. The letter requested direct feedback from the GP if a patient developed an infection or complication, which could be related to the patient's procedure.
- The pharmacy department worked well with the other departments in the hospital. The pharmacist told us that they could bring any issues up with heads of departments or they could add information into departmental newsletters.

Seven-day services

- The hospital operated Monday to Saturday and was open 24 hours a day, seven days a week. Nursing staff and the RMO were available to provide routine or urgent medical and nursing treatment to admitted patients 24 hours a day, seven days a week and a senior nurse was available for advice at all times.
- A pathology service was provided by the local NHS trust and could be accessed 24 hours a day. All results had to be phoned through to the ward/ theatres as the hospital did not have access to the trust's electronic database.
- The radiology department could be accessed during the week and had an on-call rota to cover out of hours. The hospital had a service level agreement with a local NHS trust to access radiologist cover out of hours. This meant that X-ray images were reported on out of hours in an emergency.
- There was an out of hours on call theatre rota for theatre staff with three staff on call overnight. Should any patients need to return to theatre staff were called in and then did not work the following day.
- Staff told us that all consultants were contactable at all times during their patients stay. Patients we spoke with said they were visited by their consultant and received daily reviews, seven days a week.
- Physiotherapy services were available over the weekend.

Access to information

- We were not assured that all the relevant information needed to deliver effective care and treatment was always available to relevant staff. There was a lack of private pre-operative assessment notes and communications in the patient record this included no photographs or consent to photography, no copies of letters to patients, staff therefore did not always have access to all of the patients information.

- Test results were obtained daily and the ward clerk would phone through to the local trust every morning to get blood results; as there was no access electronically. In emergency situations the ward staff would phone through to the pathology laboratories at the trust to access urgent results. The ward clerk had received in house training on how to accept results and what to do with these results. Although staff reported this to be time consuming they did not identify any significant safety issues and it was embedded into the ward routine.
- There was no electronic system for sending GPs discharge summaries, paper copies were posted out to surgeries. This practice was agreed with the clinical commissioning group until enough GP practices could supply secure email addresses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for medical photography was not obtained in a consistent manner; however, steps were taken immediately to resolve this.
- Consent forms for surgical procedures were not being checked adequately during the safety-checking element in theatre. There had been an event associated with consent form checking ,
- However, nursing staff had a clear understanding of what consent was and when it was required. All staff we spoke with had awareness of the Mental Capacity Act 2005 and could explain what a best interest decision involved. A recent example was given when the hospital followed the requirement of the Mental Capacity Act 2005. A staff member told us of an incident when a patient had limited capacity to consent for a life changing operation. This had been managed in an appropriate manner and in accordance with legislation.
- The majority of staff told us that the hospital rarely accepted patients who had limited mental capacity but all assured us if a patient developed post-operative delirium they would seek advice about initiating a Deprivation of Liberty Safeguard. The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005 and allow restraint and restrictions to be used only if they are in a person's best interests. None of the staff we spoke to had ever had to apply Deprivation of Liberty Safeguards.

Are surgery services caring?

Good

We rated caring as good because:

- Patient feedback about the service was consistently good.
- Staff took time to interact with patients and their relatives in a respectful and considerate manner.
- We observed good attention to patient confidentiality, privacy and dignity.

Compassionate care

- The patient satisfaction report for March to May 2016 showed that overall, 91.2% to 100% of patients were satisfied with their overall experience at Winfield Hospital. During this period 100% of in-patients reported being treated with dignity and respect. The patient satisfaction survey results were analysed every week and the hospital were sent 'hot alerts' from the external company. These could be positive or negative feedback and the alert indicates if the patient requires further feedback from the hospital.
- In the first quarter of 2016 satisfaction survey results showed that between 99% and 100% of NHS day case, inpatient and private patients would recommend the service. The response rate from patients was poor for private services and ranged between one to four per cent and the best response rates were for NHS inpatient services and ranged between nine to 55%.
- Staff took time to interact with patients in a respectful and considerate manner. We observed good interaction between a patient, an anaesthetist and a surgeon. We followed a patient's journey through anaesthetic, recovery and discharge. We observed the theatre staff, and nursing staff being attentive, respectful and kind and they introduced themselves at every opportunity.
- We spoke with three inpatients who all stated they had been treated with kindness, dignity and respect. Staff addressed patients by surname until told otherwise. In the Public Health England Surveillance and Patient Led Assessment of the Care Environment scores the hospital scored higher than the England average for privacy, dignity and well being

Requires improvement

Surgery

- We reviewed 20 written accounts of inpatient stays, every account praised the staff, the ward and the treatment received. One patient wrote they had received "first class care".
- We observed good attention to patient confidentiality, privacy and dignity. Doors were closed during staff and patient interactions and surgeons knocked whenever they entered a patient's room. Patients we observed in the operating theatres were fully covered in the pre-operative and post-operative period to preserve their dignity.

Understanding and involvement of patients and those close to them

- Patients and their relatives were kept informed and involved in decisions about their care and treatment. We spoke with one patient who stated that staff had been caring and thoughtful towards their relative, offering them regular refreshments and keeping them up to date with all of their family member's care needs during a very stressful time.
- An anaesthetist was seen to take a considerable amount of time explaining a procedure to an elderly patient. The surgeon explained how they would follow up the care and recovery with a phone call and what the patient should do if they had any concerns.
- We witnessed staff talking to patients' relatives, who were waiting anxiously in their relatives' rooms. Staff spent time reassuring relatives, offering them refreshments and informing them when the patient had entered the recovery room after the operation was completed.

Emotional support

- Staff offered emotional support to patients that were very anxious or in pain. A report from the patient satisfaction survey 'hot alert' identified a certain nurse who stayed by a patient's side until they were pain free, stating that the amount of care and compassion was "amazing".
- Privately funded patients had access to open visiting as opposed to NHS patients, however staff told us that they would never impose visiting times if this compromised a patient's emotional wellbeing.

Are surgery services responsive?

Good

We rated surgical services as good for responsive because:

- When complaints were made they were responded to in a timely manner. The daily huddles were used as a way to communicate feedback and learning from complaints. Complaint outcomes were also shared via a weekly newsletter and departmental meetings.
- Waiting times, cancellations and delays were minimal and managed appropriately.
- The needs of different patients were considered in the planning and delivering of the service.
- Services were planned to meet patients' needs. The hospital had worked with the local clinical commissioning group to identify the needs of patients who are waiting for cardiology diagnostic investigations
- The flow of admissions and discharges through the hospital was well organised.

However

- Staff told us there was no dementia champion within the hospital and there was no formalised training for caring for patients living with dementia or patients with a learning disability.

Service planning and delivery to meet the needs of local people

- The hospital had taken on an increasing amount of work from the NHS since it opened in 1992. During the inspection period (April 2015 to March 2016) 54% of the 5,118 inpatient and day case admissions were NHS
- The accommodation and facilities were appropriate for the care delivered. The hospital had suitable access for disabled visitors and lifts to gain access to the ward area.
- The hospital had recently developed a cardiology service as part of their NHS contract. They had worked with the local clinical commissioning group to identify the needs of patients who were waiting for cardiology diagnostic investigations.
- The senior management team stated that there was a plan in place to have a permanent magnetic resonance imaging scanner (MRI) on site to reduce delays in investigations, as the hospital was, at that time, visited by a mobile MRI scanner once a week.

Requires improvement

Surgery

Access and flow

- NHS referral to treatment waiting times (RTT) requirement, meaning patients begin their treatment within 18 weeks of referral, was changed to a guideline in June 2015. However, the hospital saw 100% of patients from April 2015 to March 2016 within an 18-week period; an exception was in November when these figures dropped to 97%. The hospital told us that endoscopy waiting times were within a six week time frame. Private patient's waiting times were not audited.
- Both NHS and private patients told us that they did not have to wait a long time for an appointment to see a consultant and that the most suitable admission dates had been discussed and agreed with them before being finalised.
- The administration team told us that if surgery cancellations occurred, both the patient's consultant and the ward manager would discuss this with the patient at the earliest opportunity and arrange an alternative admission date.
- The hospital reported that they had cancelled 80 procedures for non-clinical reasons during the relevant inspection period (April 2015 to March 2016) but all patients were offered another appointment within 28 days of the cancelled appointment. The senior management team informed us that this was due to the breakdown of one of their radiography machines.
- Systems were in place to manage the flow of patients through the hospital and we observed the flow of patients to be well managed and without delays. As part of the surgery booking process, the consultant agreed suitable admission dates with patients before completing booking forms. These were reviewed by the booking team, then the theatre and ward managers, so that the availability of theatres and beds could be checked. Both managers would then accept or reject the proposed date based on availability. The booking forms would then be returned to the booking team, who would either add the patient to the theatre list or if dates were unavailable, update the medical secretaries who would then organise another suitable date.
- As part of the admission process, patients' admission times were staggered to enable staff to manage admissions and to reduce their waiting times. Patients told us that they had been admitted in the early afternoon if their surgery was not due to take place until later that day
- The senior management team informed us that the average length of stay for a patient was less than three days due to the elective nature of the admissions and compliance with the enhanced recovery programme (ERP). Patients told us that they had not been on the ward for more than three days and were due to be discharged either that day or the day after.
- Patients told us that they had been taken to the ward following admission and taken to theatre for their surgery less than two hours later. They stated within that time, the consultant, the anaesthetist and physiotherapist, if applicable, had seen them and explained what would be happening and when.

Meeting people's individual needs

- Patients told us that they were well informed about their treatment. They stated that the consultant, anaesthetist, nursing staff and physiotherapists explained what would be happening during their admission and answered all of their questions regarding their surgery and aftercare. Staff told us that they did not encounter patients living with dementia very often, but patients were screened as part of the pre-admission process.
- Patients with a learning disability, patients living with dementia, and patients with particular cultural requirements had their needs pre alerted to the ward team by the booking teams.
- Patients living with dementia were accommodated in bedrooms situated close to the nurses' station. Staff also made arrangements to allow family members and carers to stay at the hospital to reduce stress as much as possible. Staff told us there was no dementia champion within the hospital and there was no formalised training for caring for patients living with dementia or patients with a learning disability.
- If patients were identified as having complex needs, staff told us that any issues were discussed with patients' families to determine whether additional requirements or measures were needed.
- The hospital had access to translation services, which were provided by an external company. Staff told us that the information for the services was available in the nurses' office and the services were provided over the telephone or in person, depending on the circumstances. Although the majority of staff stated they did not use family members to act as translators, one staff member stated that they had, on occasions, asked

family to translate. Translation and signing for the deaf information was also included in the Winfield newsletter which was emailed to all staff and displayed on notice boards around the hospital.

- The catering staff told us that they could cater for patients with religious, cultural and special dietary requirements if requested. To ensure that these requirements were met, patients were asked for their preferences at pre-admission clinics. Patients stated that there were lots of meal choices and were given advice from nursing staff, if they had difficulty choosing.
- Patients were supported to be mobile post operatively by physiotherapy and nursing staff. Patients told us that they had been visited by a physiotherapist shortly after surgery and were advised on what exercises they needed to do and when they would need to attend physiotherapy.
- Staff told us that patients with diabetes were always scheduled first on theatre lists to minimise any risks from prolonged starvation times.
- Visiting times were different for private and NHS patients. We asked staff if this distinction caused any problems and staff could not identify any situations where this had caused any issues. Staff did tell us that requests for out of hours visiting was always considered on an individual basis.
- The patient satisfaction survey asked if patients were offered a good food choice, over a three-month period of March to May 2016 the results were consistently high.
- Patients on the ward spoke highly of the food and the menu provided at the hospital a patient who was a vegetarian told us there was a good choice of high quality food for vegetarians. Another patient told us that the food had been tasty and there had been a good choice. This was important as the patient already had a gastric band prior to admission and valued taste over quantity. Another patient rated the food and choice very highly and commented to us that the nursing staff had helped them with his choice of food.
- The hospital participated in Public Health England Surveillance and Patient Led Assessment of the Care Environment (PLACE). The hospitals scored higher than the England average for organisational and ward food.
- We discussed with the chef the specific dietary needs of some religions and they confirmed that this would always be catered for. They told us that if they were unable to fulfil these needs in house, there were providers that dealt with specific foods and these would be contacted. Ward staff also told us that food could be provided according to the person's needs, for example, to take into account patients' allergies or intolerances.

Learning from complaints and concerns

- The hospital received 36 complaints in the reporting period (April 2015 to March 2016). Of the 36 complaints, 28 were from private patients and eight were from NHS patients. CQC did not receive any complaints during the reporting period but received one in June 2016.
- Leaflets on how to make a complaint were available for private patients on the ward and in the reception areas. Leaflets providing information on how to raise a concern for NHS patients were not available on the first day of our inspection. When we queried this with the general manager, it was found that the NHS complaint leaflet required review in July 2016 and staff had removed them. Leaflets were subsequently made available.
- We reviewed four complaints and saw they all had been acknowledged within two days in line with the complaints policy. Where a response was delayed the patients were informed. Before investigating a complaint, the patient's consent was requested to discuss information with the consultant in question. Patients were offered meetings, where appropriate, and we saw that responses to complaints contained an apology and there was evidence that the concerns raised had been fully investigated.
- The general manager was responsible for investigating non-clinical complaints and the matron was responsible for investigating clinical complaints. An overview of all complaints was discussed at a senior level such as clinical governance meetings.
- As part of the monthly governance report, sent to the Ramsay Health Care corporate team, any new complaints requiring investigation were reported. The daily huddles were used as a way to communicate feedback and learning from complaints. Complaint outcomes were also shared via a weekly newsletter and departmental meetings.
- A senior member of staff informed us if a complaint involved a particular aspect of care, for example, nursing care, then it was discussed with the nurses in question, as well as the relevant ward staff. Following the investigation, the learning outcomes from the

complaint were shared within the department within the weekly newsletter and/or at departmental meetings. Staff told us that they were updated on complaints and the learning outcomes from them.

- The complaints and their outcomes were shared with the heads of department but only if it had led to a change in practice. The general manager told us that they usually discussed the complaints they were investigating with the senior management team but they did not produce a formal report on them.

Are surgery services well-led?

Requires improvement

We rated surgery as requires improvement for well led because:

- The hospitals strategy identified that certain items such as patient satisfaction should be discussed at team meetings as standard agenda items however this was consistently not discussed at senior level meetings.
- Minutes of the clinical governance and senior management team meetings did not record sufficient detail of discussion of all agenda items. This did not ensure a robust audit trail and evidence that the planned agenda items regularly reviewed
- The risk register was reported to be reviewed at the medical advisory and clinical governance committees. On review of the minutes evidence of discussion was not clear as the minutes did not record the discussions that took place.
- The medical advisory committee meetings were not well attended which raised questions around valid proceedings.

However

- There was evidence of innovation, and improvement to hospital services.
- Senior staff members had a visible presence around the hospital and there was strong leadership on the ward.

Vision and strategy for this this core service

- As part of Ramsay Healthcare, the hospital worked alongside the values entitled 'The Ramsay Way.' All clinical departments use the values as part of their departmental local strategy. All staff we spoke with were aware of the hospital's values and told us they aimed to provide superior patient-centred care.
- Part of the hospitals strategy was to display high levels of commitment to their patients through regular audit activity. This was to be measured by patient satisfaction results, environmental and clinical audit and accountability throughout the hospital for infection prevention and control. The strategy identified that these items should be discussed at team meetings and patient satisfaction was identified as a standard agenda item on the clinical governance committee minutes, however this was consistently not discussed at the meetings.

Governance, risk management and quality measurement for this core service

- The hospital had a recent provider visit, this was requested by the new in post manager. `This was an internal led inspection by Ramsay Health Care UK to provide the new hospital manager with an up to date picture of the position of the hospital. The review was carried out under the CQCs five questions, are services safe, effective, caring, responsive and well lead. The report included trends and observations and Ramsay used this format as a guide to help the hospital develop an in depth action plan. We saw copies of the action plan from the provider report and this showed clearly what actions had been taken.
- The hospital committee structure included a medical advisory committee (MAC), clinical governance committee and a senior management team committee. All committees had meetings with corporate set agendas. There was poor representation from specialties at the MAC meetings: this was clearly an issue and was discussed in the minutes of the MAC meeting in June 2016. We reviewed the attendance of this meeting, six members of the MAC attended, eight apologies were given and two surgeons were called away or delayed. Questions about valid proceedings had been raised and it was to be considered that as part of granting practising privileges, participation in the MAC would be mandatory.
- The hospital medical advisory (MAC) committee met every three months. The role of the MAC was to ensure that competent medical practitioners provide clinical

services, procedures or interventions safely. Standard agenda items such as practising privileges were discussed and feedback from the national/regional MAC meetings were shared and actioned.

- We saw in the minutes of the clinical governance committee meeting that learning from the never event which occurred in January 2016, were discussed. The set agendas for these meetings covered wide and varied topics from drugs and therapeutics to staff engagement, however there was often limited discussion and no detail recorded for some of the standard agenda items such as the audit programme and policy updates.
- Meetings of heads of departments were held each month, chaired by the hospital manager. The format and reporting had become more formalised in recent months with use of slides, which the leads populated with performance data. We reviewed these meeting minutes and they were well presented, easy to follow and comprehensive.
- Incidents were discussed at a range of internal hospital meetings, including the clinical governance meeting and the MAC meetings where the chair would review any new incidents and select specific ones to discuss.
- Incidents were also discussed at the health and safety committee meetings, team meetings and the daily 'huddle' which was attended by representatives from each department.
- The hospital risk register did not separate general or corporate business risks from those within the control of the hospital and it mainly contained corporate level risks, which were relevant to all Ramsay hospitals. Local risks were placed on the risk register usually because of a risk assessment in a department had identified a risk, this was escalated to matron or the registered manger. New clinical risks would be discussed at the clinical governance meeting and this was evident in the minutes we reviewed. When a risk required further investigation the clinical governance committee would recommended an audit, an example of this was a notes audit which had been undertaken due to information not being included in all notes. Senior staff reported there was robust challenge at the clinical governance committee and medical advisory committee.
- The risk register was reported to be reviewed at the medical advisory and clinical governance committees. On review of the minutes evidence of discussion was not clear. We pointed this out to senior staff who agreed that in places the minutes did not reflect the discussions that took place; although they were confident what occurred was appropriate.
- Minutes of the clinical governance and senior management team meetings did not record sufficient detail of discussion of all agenda items. There was no evidence of complaints being reviewed or discussed at the clinical governance committee. We were told these would be covered at the senior management team meetings. On review of the minutes, despite complaints being a regular agenda item, there was no recorded discussion but a reference 'as per HODs meeting.' This did not ensure a robust audit trail and evidence that the planned agenda items were reviewed.
- We were not assured that audit work was carried out in sufficient detail. Audits of the WHO surgical safety checklist remained three monthly despite serious untoward incidents and a never event. Over this three month period only ten sets of checklists were audited retrospectively and only ten observations of the checklist taking place were completed. The hospital followed the Ramsay corporate clinical audit programme and had recently appointed to the post of clinical quality lead to monitor and have oversight of the clinical audit programme and ensure action plans from departments were progressed. Additional audits could be added if required. This was a developing role and it was planned to encompass complaints, clinical audit and patient satisfaction. A monthly report would be prepared for the clinical commissioning group (CCG) based on the current governance report the hospital submitted each month to the corporate clinical governance committee.
- Ramsay Health Care UK had recently issued new standard operating procedures in relation to surgical safety. Winfield Hospital had received the guidance which would be circulated to all staff, with associated training being competed by end of September 2016. The guidance included 'stop before you block' which aimed to reduce the risk of the incorrect site being anaesthetised through a series of checking steps.
- There was no system of assurance for environmental cleaning audits as the results were only fed back verbally with no record of areas requiring remedial action. There was also a lack of detail for the theatre

cleaning schedules which may not provide assurance that the required standards were being met. There was a plan to implement a new cleaning manual but this was not in place.

Leadership / culture of service related to this core service

- Staff told us the registered manager and matron were visible and accessible and had an 'open door' policy. The registered manager met all new staff as part of their induction. The manager visited the ward each morning and other departments during the day. There were plans to relocate the manager's office so that they were more visible to staff and patients. The matron had already re-located to an office off reception, which allowed staff and patients better access.
- There had been a period of change with senior management staff and this had a negative effect on morale. We were told this was slowly improving.
- The staff we interviewed on the ward spoke highly of the senior management team and we were told all staff were given individual Easter eggs.
- The registered manager had been in post since November 2015 and had instigated a number of reviews and made a number of changes. Following the never event they had met with a range of staff and requested a provider review of the whole hospital. The actions identified, were in the process of being completed during the inspection and we saw a very engaged and positive attitude from all the senior ward staff we spoke with about this report.
- The senior management team met weekly and then had a monthly formally documented meeting. The heads of departments met monthly and important information was cascaded down to individual departments via departmental monthly meetings.
- We were told that the manager attended some inter-departmental meetings when able and we saw documented evidence of attendance at physiotherapy meetings. During this meeting the manager discussed issues relating to staffing, marketing and departmental plans.
- Members of the ward team we spoke with spoke highly of their senior nursing staff and this was evident through the positive culture on the ward.

Staff engagement

- The most recent staff survey in 2016 had returned scores in some areas worse than expected. The five lowest scores were,
  - Corporate leadership-listen and act upon employees' views and concerns
  - Corporate leadership-communicates everything we need to know from them
  - Corporate leadership-are visible to employees
  - In comparison with people in similar jobs in other companies I feel my pay is fair
  - The SMT take the views and opinions of staff seriously
- The senior management team had discussed some ideas for improving teamwork and staff morale and had developed an engagement strategy. Some of the areas for improvement suggested were a staff forum with the general manager, better promotion of staff benefits, a job swap initiative and recognition of performance, which was above and beyond expectations
- There had been a period of time where the cleaning staff in the theatre department had not had regular supervisor oversight. This had been addressed and now regular team meeting for these staff were in place.
- The hospital had its own newsletter, this covered topics such as talks, competitions, financial information and patient feedback. Staff reported this to a useful and easy to read document. This added to the feeling the hospital had of inclusiveness for all staff. The newsletter also explained what the purpose of the daily huddle meeting was for and encouraged staff from at all levels to attend.
- The newsletter also helped to prepare the staff for the upcoming CQC inspection and signposted staff to websites that would help prepare them.

Public engagement

- All NHS patients could report on their stay via the NHS choices website. The feedback was very positive and the hospital was able to respond to these reviews via the website.
- The recent engagement strategy identified actions for involvement with local charity events.
- The hospital used the NHS friends and family test for private and NHS patients in the hospital and a patient satisfaction survey. The patient satisfaction survey was run by an external company and although the response rate was poor the feedback was consistently positive.

Requires improvement

Surgery

- The hospital participated in Public Health England Surveillance and Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people (known as patient assessors) assessing how the environment supported the provision of clinical care.

Innovation, improvement and sustainability

- The ward was in the process of using the Shelford Safe Staffing tool. This is an evidence-based tool that enables nurses to assess patient acuity and dependency to ensure that the nursing establishment reflected patient needs in acuity/dependency terms.
- The provider report identified numerous actions one of which was protected hours for the Infection control lead. We were assured that this had been implemented and the lead's hours were now increased to 20 hours a month.
- The sterile services had recently extended their working hours to cover services for 24 hours.
- The hospital had recently discussed developing a cardiology service as part of their NHS contract. This involved working with the clinical commissioning group (CCG) to identify the needs of patients who are waiting for cardiology diagnostic investigations. Services that were to be offered were 24 hour tape and echo cardiograms and this service was due to be commence in April 2017.
- There was a plan for a joint venture to have a permanent MRI magnetic resonance imaging scanner on site. Currently the hospital had a visiting mobile MRI scanner once a week which caused delays to investigations and follow up treatment.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at Winfield Hospital operate from 8.30 am to 8.30 pm, Monday to Friday and alternate Saturday mornings. The department sees both private and NHS patients. Self-funding or insured patients can access services by direct self-referral. NHS patients are referred by their GPs via the NHS e-referral system. The department provides consultant-led clinics in a range of specialities, including orthopaedics, general surgery, ENT, maxillofacial, ophthalmology, dermatology, gynaecology, cosmetics and urology. There are also nurse-led pre admission clinics and general nurse appointments for services such as removing dressings, sutures and plasters. There are 11 consulting rooms and two treatment rooms.

The outpatients department is staffed by registered nurses and healthcare assistants. There were 30,101 outpatient total attendances in the reporting period April 2015 to March 2016. The hospital ceased providing outpatients services to children and young people in April 2016, although at the time of our inspection they were seeking to appoint a registered children's nurse and resume this service.

Diagnostic imaging services provided include plain X-ray, fluoroscopy and ultrasound. There is a mobile image intensifier and a mobile x-ray unit. There are also mobile services provided by Ramsay UK Diagnostics twice weekly for magnetic resonance imaging (MRI) and once a fortnight for computed tomography (CT). There were plans to install a permanent MRI facility on the hospital site.

Physiotherapy services are provided to outpatients and inpatients. Facilities include a fully equipped gymnasium with an anti-gravity treadmill and treatment rooms.

Services include hydrotherapy, treatment of sports injuries, ultraviolet treatments, musculoskeletal assessment and treatment, post-operative rehabilitation, pilates classes and a 'back school'.

We visited the outpatients and diagnostic imaging departments over two weekdays. We spoke with staff, including nurses, doctors, managers, therapists and support staff and looked at care records. We spoke with three patients during the inspection and we received written comments from seven patients who had visited outpatient services, including physiotherapy and X-ray in the weeks leading up to our inspection. Prior to and following our inspection, we reviewed performance information about the hospital.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

We have rated outpatients and diagnostic imaging as requires improvement overall because:

- Staff did not always receive feedback following adverse incidents.
- Medicines were stored in the diagnostic imaging department at temperatures which were above recommended levels.
- There were inadequate systems in place to track medicines and prescription pads in outpatients in order to prevent theft or misuse.
- The imaging table in the X-ray room was not height adjustable. Staff had to use portable steps to assist post-operative patients on to the table, posing the risk of injury to staff and patients
- The provider was unable to provide us with accurate and up-to-date information in respect of staff compliance with mandatory training. We could not therefore be assured that staff had the required knowledge of safety systems, processes and practices. Staff in outpatients and physiotherapy were not up-to-date with role-specific competencies.
- The hospital had taken few steps to support people in vulnerable circumstances, such as patients living with dementia or patients with a learning disability. Staff in outpatients were not able to describe any examples of support which may be provided to such patients.
- Patient information leaflets relating to surgical procedures did not indicate that they could be made available in languages other than English or other formats, such as large print, braille or easy read. Staff told us they had never been asked for information in other formats and they were not aware of any facility to provide this.
- Information on how to access the complaints system was not well publicised and patients were not offered support with their complaint.
- Patients attending the diagnostic imaging department, who were required to undress, were not offered sufficient privacy while waiting for their treatment.
- Governance and reporting processes were not fully effective to ensure effective communication 'from ward to board' and 'from board to ward'.
- There was insufficient evidence that managers had oversight of all performance, including risks to quality and safety. The recent provider visit had highlighted weakness in governance processes which still needed to be improved. For example, there was insufficient oversight of mandatory staff training and little evidence that audits were consistently taking place as planned or learning was taking place following these audits.
- The management team had suffered from a period of instability with a significant number of management changes. There had been a difficult transition period while managers settled in. Staff meetings did not occur regularly and some staff consequently felt they did not a have a voice.
- The recent staff survey had yielded a disappointing response and highlighted some worrying themes. Staff engagement and involvement needed to improve to address issues which affected staff morale and make them feel more valued.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We have rated this domain as requires improvement because:

- Staff did not always receive feedback following adverse incidents.
- In the diagnostic imaging department medicines were stored at temperatures which were above recommended levels.
- Weekly checks of resuscitation equipment had not taken place the week prior to our inspection.
- There were inadequate systems in place to track medicines and prescription pads in outpatients in order to prevent theft or misuse.
- The imaging table in the X-ray room was not height-adjustable and staff had to use portable steps to assist post-operative patients on to the table.
- The provider was unable to provide us with accurate and up-to-date information in respect of staff compliance with mandatory training. We could not therefore be assured that staff had the required knowledge of safety systems, processes and practices.

However,

- Staff understood their responsibilities to report incidents and were encouraged to do so.
- Risks to patients were assessed and their safety was monitored and maintained.
- There was evidence of learning and improvement following two incidents in diagnostic imaging and an incident in the physiotherapy department.
- Departments were mostly clean and tidy. Staff observed standard infection control precautions and disposed of waste appropriately.
- Premises and equipment were designed and maintained to keep people safe.

Incidents

- There were no never events, serious incidents or deaths reported in outpatients and diagnostics from April 2015 to March 2016.
- During the same reporting period, 59 clinical incidents were reported in outpatients and diagnostic imaging departments. This is just below average, when compared with the seven other independent acute hospitals we hold this type of data for. There were no discernible trends. No non-clinical incidents were reported.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and told us they were encouraged to report them. They expressed mixed views about how effective feedback was following incidents. In the outpatients department staff told us they would only hear about incidents if they had been directly involved in them. The senior management team had acknowledged that there was work to do to support shared learning and "close the loop" following incidents. They told us that incidents were now discussed at daily huddles.
- Outpatients' staff were not able to describe any untoward incidents which had resulted in changed practice. Physiotherapy department staff felt well informed with regard to incidents and they were well briefed by their manager. Staff told us about a recent incident where a patient had had acupuncture needles left in too long because staff had not heard the timer sound. In response to this incident the department had changed their practice. Staff now carried the timer on their person and informed a second member of staff when this treatment was carried out.
- In the radiology department an incident had occurred where a patient's ultrasound images were mixed on the picture archiving and communications system (PACS).This had resulted in one patient having to be re-scanned. There had been a change in process implemented and a healthcare assistant had been employed who undertook pre-procedure checks. These changes reduced the risk of a similar incident occurring. A second incident in radiology had involved a patient being re-called for a second CT scan, following incorrect protocolling. The radiology manager had investigated this incident and reported it to the radiation protection

advisor. Protocols in the department were changed and all CT scans now had to be protocolled by the radiologist who was reporting the scans. Learning had been shared within the Ramsay Health Care group.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the trust to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Staff we spoke with were all aware of this and could describe their responsibilities, but could not recall any incidents where the duty had been observed. However, the radiology manager described how the department had apologised to the patients affected by the ultrasound incident (described above), and told us they offered an apology and explanation to each patient.

Cleanliness, infection control and hygiene

- Departments were mostly visibly clean, tidy and uncluttered. In outpatients we saw daily and weekly equipment cleaning checklists for equipment in the clinic rooms. Staff signed to confirm equipment had been cleaned. Staff told us that equipment should be tagged with green tape to show that it had been cleaned but we saw no evidence of this tape being used in any of the clinic rooms. We found all equipment was clean, with the exception of an examination lamp, which was dusty.
- In the radiology department a health care assistant was responsible for the specialist cleaning of probes and documentation confirmed that the equipment had been cleaned. Staff also documented cleaning checks in the clean utility area, although we noted checks were not recorded for three days during July 2016.
- We checked four patients'/visitors' toilets in outpatients. Three of them were clean. One toilet had an unpleasant odour and there was paper on the floor. There was no information displayed to show when the toilets had last been cleaned.
- There was a link nurse in the outpatients department whose role was to provide advice and support to colleagues on infection prevention and control (IPC) issues. There was a resource folder the nurses' office; however this contained only a set of minutes from an infection control meeting held in September 2015. There was no evidence of staff training or IPC audit results. Staff told us they did not receive feedback following infection control audits, unless a problem had been identified.
- There were no cases of Clostridium difficile, Methicillin-resistant Staphylococcus Aureus (MRSA), methicillin-sensitive Staphylococcus Aureus (MSSA) or Escherichia Coli (E-Coli) reported from April 2015 to March 2016.
- There were adequate hand-washing facilities and hand gel dispensers in departments, including at entrances to departments and on reception desks. We saw little information displayed to encourage patients and visitors to clean their hands.
- Staff observed the 'bare below the elbow' policy in clinical settings. There was adequate provision of disposable protective equipment such as gloves and aprons.
- The hospital scored 89% for cleanliness in the patient-led assessment of the care environment (PLACE) for the period February 2015 to June 2015. This was lower than the England average.
- Patient satisfaction survey results (April 2016) showed that only 64% of respondents saw staff wash their hands. This was an improvement on previous scores but the hospital had taken steps to remind staff of the importance of cleaning their hands in front of patients.
- The provider's hand hygiene policy stated that audits should be conducted at least six monthly. We saw that these audits had been carried out in September (scoring 98%), December 2015 (scoring 96%) and April 201 (scoring 100%).
- An infection prevention and control audit in radiology in July 2015 scored only 69% overall. There was no action plan to address this performance and quarterly audits had not taken place since then, in accordance with the audit schedule.

Requires improvement

Outpatients and diagnostic imaging

- Waiting room furniture was clean and in good condition, with appropriate covering which could be wiped clean.
- Clinic rooms were carpeted, although all but two had linoleum covered cut out sections in treatment areas. Staff confirmed that a risk assessment had been carried out by the infection control team and that no clinical interventions took place in the two fully carpeted rooms. This was in accordance with Department of Health guidance.
- Clinic rooms were equipped with wash hand basins with elbow-operated taps, soap, hand gel and paper towels. There were appropriate receptacles provided for the disposal of waste, including clinical waste and sharps.
- There was an appropriately equipped dirty utility room, which was clean, tidy and secure.
- Staff took precautions when they saw patients with suspected communicable diseases or infections. Staff in radiology described how they would arrange their lists to accommodate infectious patients at the end of the list.

Environment and equipment

- Premises were designed and maintained to keep people safe. However, the medical records department was accommodated in a room without adequate natural light or ventilation. A staff member told us that the working environment was frequently too hot and there was no means to control the temperature. This had recently been reported to the operations manager and the staff member was confident that the issue would be looked into.
- The outpatients and diagnostic imaging departments were mostly well equipped. Equipment was maintained and fit for purpose.
- We checked a range of equipment, appliances and consumables. Equipment was clean and was labelled to show when it had last been serviced and/or checked for electrical safety. Consumable items were safely and securely stored and were in date.
- We checked the resuscitation trolley which was located to ensure easy access to outpatients, X-ray or physiotherapy staff. There was evidence of daily checks, with a few odd days omitted. Weekly checks had not been carried out consistently and the equipment had not been checked in the week prior to our inspection.
- Staff told us that they had to use steps to assist post-operative patients onto the imaging table as it did not have a rise and fall function. Staff told us they had been shown how to move patients safely by the physiotherapy team and they ensured two staff were always present. This had been logged by the radiology manager as a risk and there were plans to upgrade the room to provide a height-adjustable table.
- The hospital scored 91% for the condition, appearance and maintenance of premises in the PLACE (February 2015 to June 2015). This score was slightly lower than the England average.

Medicines

- Medicines were not always safely stored. In outpatients medicines were stored in locked cupboards or a refrigerator in the treatment room, with the keys held by the nurse in charge. Controlled drugs were not kept in outpatients. We saw that regular checks had taken place to monitor the fridge temperature and the temperature in the treatment room. Both were within an acceptable range at the time of our inspection.
- However, in the diagnostic imaging department medicines were not appropriately stored. The department held a small amount of pain relieving medicines used in ultrasound-guided joint injections. These were stored in the locked clean utility room. Documentation showed regular checks were made to measure the temperature in the room and that the temperature was regularly above 25 degrees Celsius. This is above the recommended storage temperature for some medicines. The radiology manager had taken advice from the pharmacy manager, who had obtained advice from the manufacturer of the medicines. They advised that the medicines could be stored safely at a temperature of 30 degrees Celsius. However, two entries in August 2016 showed that room temperatures exceeded this. We brought this to the attention of the hospital manager during our inspection and they committed to have the medicines moved to another area.

Requires improvement

Outpatients and diagnostic imaging

- Systems to track medicines in outpatients were not robust. Nursing staff told us that medicines, such as injectable steroids, would be provided to consultants on request and they relied on those consultants to tell them what had been administered. If they did not provide this information, nursing staff would check with the relevant consultant's secretary.
- Prescription pads were not managed effectively so as to prevent theft or misuse. Prescription pads were provided to the outpatients department by pharmacy and the numbers were logged. Pads were then stored in pouches in consulting rooms. There was no tracking system in place to prevent theft or misuse.

Records

- Records were safely stored and available when required. There was an effective system for ensuring medical records were available for outpatient clinics. Staff in the medical records department collated patients' records 48 hours before the clinic.
- Consultants who had secretaries off site were permitted to take records off site. The provider told us that the secretaries were responsible for ensuring that the records were returned to Winfield Hospital 72 hours before the next clinic date. This meant the hospital did not always have access to the complete patient record.
- In the three months prior to our inspection, there were no cases reported where patients' medical records were not available at their outpatient appointments.
- We looked at a sample of seven patients' records. They were legible, accurate and up-to date.
- The diagnostic imaging department received all referrals for imaging on paper request forms, which had to be entered manually onto the computer system. Staff told us that problems with handwriting and print quality made this quite challenging at times.

Safeguarding

- The hospital matron was the adult safeguarding lead for the hospital. Two nurses in outpatients were not able to tell us who the lead in the hospital was; they told us they would report concerns to their head of department. We saw a safeguarding children flowchart displayed in the nurses' office in outpatients. There was no similar guidance which set out reporting arrangements for safeguarding vulnerable adults. Staff in radiology understood and could describe their responsibilities around safeguarding vulnerable adults and children.
- The children's safeguarding lead for Winfield Hospital was the safeguarding lead for Ramsay Health UK and they were trained to level three[HB1][KH2].

Mandatory training

- Most of the staff we spoke with in outpatients told us they were not up-to-date with their mandatory e-learning. They said this was due to their workload and staffing levels. One staff member told us that staff had been encouraged to complete this learning at home in their own time (and be paid for this) but said that most staff chose not to do this. There was a lack of management oversight of the training status of staff in the outpatients department for both clinical and non clinical staff.
- Staff in the diagnostic imaging department told us that they had completed their annual mandatory training update; however the radiology manager expressed concerns that the on line system used to track training compliance did not reflect this.
- The provider was unable to provide us with accurate and up-to-date information in respect of staff compliance with mandatory training. We could not therefore be assured that staff had the required knowledge of safety systems, processes and practices.

Assessing and responding to patient risk

- Risks to patients were assessed and their safety was monitored and maintained.
- There were clear pathways and processes for the assessment and management of patients who became unwell and required hospital admission. Staff we spoke with could describe what to do if a patient became unwell, the procedure for summoning emergency help, and where their nearest resuscitation equipment was.
- There were processes in place to ensure the right person received the right radiological scan at the right time. For example, staff used an eight-point identification check for all patients, which included checking name, date of birth, address, area to be examined and which side.

Requires improvement

Outpatients and diagnostic imaging

- The imaging service ensured the World Health Organisation (WHO) Surgical Safety Checklist was used when carrying out non-surgical interventional radiology. This had been modified to suit the procedures undertaken in diagnostic imaging, which included ultrasound-guided joint injections for pain relief, and MR arthrograms (where a dye is injected into a joint to look for damage). This had only been introduced following a provider visit in April 2016 and the process had not yet been audited.
- The Radiation Protection Advisor (RPA) was accessible for providing radiation advice. This advice was provided to all diagnostic imaging departments within Ramsay Healthcare by a large NHS Trust. The radiology manager told us the RPA was readily available for advice, and had visited the department since they had been in post. Staff could describe how and why they would contact them, and understood their responsibilities to report certain radiology incidents to the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposures) Regulations 2000. These regulations help protect patients from unnecessary harm caused by over exposure to ionising radiation. Staff gave us an example of an incident that had been reported to the RPA, but had not passed the threshold dose which made it reportable to CQC.
- The diagnostic imaging service ensured that requests for X-ray were made in accordance with IR(ME)R. We saw an up-to-date list of referrers and protocols. In a recent provider inspection carried out by Ramsay Health Care, the protocol folder had been found to be a number of years out of date. The radiology services manager had reviewed and removed any out-of-date protocols. However, there was not a single folder available to all staff, including bank and agency staff, to use as a reference guide. Staff told us they discussed queries about imaging requests verbally.
- The radiology manager was acting as Radiation Protection Supervisor (RPS) for the department, but was planning to appoint a second RPS when a new staff member started. The radiology manager had not yet undertaken the Ramsay Healthcare training for this role, but was planning to do so in November 2016.
- There were adequate signs and information displayed in the diagnostic imaging department waiting area which informed people about areas and rooms where radiation exposure took place. These included warning lights outside rooms. Radiographers told us doors were always locked during examinations to prevent people entering.
- The diagnostic imaging service ensured women (including women using the services and female staff) who were or may be pregnant always informed a member of staff before they were exposed to any radiation, and obtained signed evidence of this.
- The hospital had a service level agreement (SLA) with a large nearby NHS trust to provide radiologist cover overnight and at weekends. In the event of an emergency, staff could describe their responsibilities and the process to transmit an emergency X-ray electronically to the NHS hospital's picture archiving system (PACS) for review. There was no formal SLA for the transfer of patients who required and urgent CT or MRI scan when these facilities were not available on site, although the radiology manager told us that there was an informal understanding with the local NHS trust.

Nurse staffing

- The outpatients department was not staffed to the funded establishment at the time of our inspection. There was a vacancy factor of 1.56 whole time equivalent (WTE) nurses, of which one WTE was the manager's position, which had been vacant for a number of months and would be filled in October 2016. Although bank staff were employed to fill shifts, all of the staff told us they felt the staffing levels were not sufficient to cope with the workload at times. Staffing levels were cited as the reason staff were not up-to-date with mandatory training and staff meetings were not taking place. Staff told us that after 4pm when the reception staff finished their shift, nurses had to cover the reception desk, as well as supporting consultants in clinic. This was also the case when clinics took place on Saturday mornings.
- Staff told us that normal staffing levels would be two staff on both early and late shifts, in addition to one nurse working 9am to 5pm. We were unable to decipher rotas to confirm that this was consistently achieved.
- The matron told us that staffing levels had been set using a model which assumed 0.4 hours of nursing input per outpatient visit. Staffing levels were set in 2014.

Requires improvement

Outpatients and diagnostic imaging

- Sickness levels were mostly higher than average for nursing staff during the period April to December 2015, and lower or about average from January to March 2016. For healthcare assistants sickness levels were mostly low, with the exception of April, July 2015 and March 2016 when compared with the 26 independent acute hospitals we hold this type of data for. There were unfilled shifts during the months of January (6.7%), February (7.5%) and March 2016 (11.5%).

Diagnostic imaging staffing

- Staffing levels and skill mix in diagnostic imaging had been reviewed to ensure people received care and treatment. In March 2016, the diagnostic imaging department had taken over responsibility for all theatre screening. This had identified a need for another full time radiographer, who had recently been recruited and was due to start very soon.
- The radiology manager told us they had been using an agency radiographer to fill the shortfall until the permanent staff member started. Agency staff received a comprehensive induction to the diagnostics imaging department, which included competency-based training overseen by the radiology manager.

Medical staffing

- There were 160 doctors employed under practising privileges.
- Consultants agreed clinic dates and times directly with the hospital outpatient and administration teams. There were no concerns raised about the availability of consultants to cover their clinics.
- There was a resident medical officer (RMO) available 24 hours a day, seven days a week supplied by an external company. Staff told us this doctor could be called upon for support in an emergency situation.

Other staffing

- The outpatient department was supported by a team of administration staff and a team of five reception staff who rotated through three functions. These were: covering the hospital's switchboard from 7.30 am to 9pm, Monday to Friday, greeting, registering and taking payments from patients, and outpatients' reception from 8am to 4pm, Monday to Friday. The team was currently one staff member short and was covering the shortfall by employing bank staff. Nursing staff were required to cover outpatient reception duties after 4pm and at weekends. Staff told us this was not ideal, particularly when a chaperone was required in a clinic. There were plans to extend the hours of this function.

Major incident awareness and training

- There was a business continuity management policy (last reviewed in September 2015) which set out the requirement to develop contingency arrangements and responsibilities in the event of an unplanned major failure or disaster. The policy stated that business continuity plans should be in place and tested on a regular basis. It further stated that staff shall be trained on the emergency procedures and process, including incident handling, business continuity and IT disaster recovery, both on appointment and as part of their on-going training, and regular testing.
- Staff in outpatients did not know where to find the major incident and business continuity plan and told us they would refer to the matron.
- Staff were familiar with fire safety and evacuation procedures.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We have not rated this domain due to insufficient data being available to rate departments' effectiveness nationally.

We found:

- Patients' needs were assessed and their care and treatment delivered in accordance with legislation, standards and evidence-based guidance.
- Pre-operative assessment took place to ensure that patients were medically fit and prepared for surgery.
- The diagnostic imaging department used diagnostic imaging levels to ensure that patients' radiation doses were appropriate and commensurate with the examination they were undergoing.

- An audit undertaken of screening in theatre had shown a reduced radiation dose when screening was undertaken by radiographers and this was now standard practice.
- Staff knew how to expedite urgent review of images, including out of hours.

However:

- Staff in the outpatient and physiotherapy departments were not up-to-date with role-specific competencies.
- Nursing staff in outpatients showed a lack of knowledge and understanding of the requirements of the Mental Health Act 2005 in relation to the gaining of consent for those patients who may lack capacity to make decisions.
- The diagnostic imaging department was not working towards imaging services accreditation scheme (ISAS), but used ISO9001 as an alternative quality standard.

Evidence-based care and treatment

- Patients' needs were assessed and care planned and delivered in line with evidence-based guidance, standards, and best practice.
- Pre-operative assessments were carried out in outpatients for patients booked for surgery. This was to ensure that patients were medically fit and prepared for surgery, including anaesthesia. Patients were asked to complete health questionnaires following their initial outpatient consultation with a consultant. The questionnaires were then reviewed with them at a pre-assessment clinic. Assessments took place in a nurse-led clinic, although nurses had access to advice from consultants, including anaesthetists if required. Nurses used documented care pathways and evidence-based patient advice, relevant to the patient's condition and proposed treatment. Twice yearly audits of the pre-assessment process took place. The last one in January 2016 scored 100%.
- All but one registered nurse in the department undertook the pre-operative assessment activity. One nurse was dedicated to this each day. A number of staff raised concerns about the way in which pre-operative assessment clinics were organised. They told us there used to be a dedicated team for this activity; now the function was amalgamated into to the outpatient function. Staff felt there was lack of continuity, which increased the risk that things would be missed or not followed up, which could lead to cancellation or delay to a patient's surgery. We spoke with the matron about these concerns. They were aware that some staff did not like the current working arrangements but argued that this arrangement was the most efficient and effective use of staff, given that it was a small team. The matron told us that cancellations due to a failure in the pre-operative assessment process had reduced since the new arrangements were introduced. Data provided by the hospital supported this. There were nine operations cancelled in the six months June to December 2016, reducing to four cancellations in the following six months.
- The diagnostic imaging service used diagnostic reference levels (DRLs) as way to check the correct amount of radiation was being used to image a particular part of the body. Staff were able to locate and explain how they used these as a tool. We saw evidence that these levels were regularly audited and staff told us the radiation protection advisor (RPA) had overseen this work. We saw DRLs on display and staff could demonstrate how they referred to them in their daily work.
- The diagnostic imaging department ensured that it followed National Institute for Health and Care (NICE) guidelines for acting on radiologists' reports, such as NICE quality standard 17 for suspected lung cancer. Staff described how they communicated urgent reports to GPs, although we did not see any policies to support this. However, staff could describe an occasion when this had occurred, and they had referred a patient back to an NHS hospital for multidisciplinary team discussion.
- The radiology manager had undertaken an audit comparing screening doses for spinal theatre procedures carried out by nurses, versus those carried out by radiographers, when using a new image intensifier on trial. The results had shown a significant decrease in radiation dose to patients when screening was carried out by radiographers with the new equipment. These results had been used to strengthen the case for radiographers taking over screening of theatre procedures and to secure purchase of a new image intensifier.

Pain relief

- Staff gave patients pre-operative information at their clinic appointments, including information about pain relieving medicines.

- Patients were offered local anaesthesia for minor procedures undertaken in the outpatients department and pain relief medication to take home if required.
- Staff described simple comfort scale methods for assessing people's pain.
- In the diagnostic imaging department radiologists provided ultrasound-guided injections to administer pain relief for certain medical conditions.
- Physiotherapists used visual analogue scores to assess pain during and after treatment.

Patient outcomes

- The provider did not participate in the imaging services accreditation scheme (ISAS). Ramsay Healthcare instead used ISO9001 as their set of quality standards for the diagnostic imaging department. Staff told us this was because of the cost, relative to the department's small size.
- The outpatient service did not participate in national audits.

Competent staff

- We looked at three staff competency folders (selected randomly) in outpatients. All staff had recently completed core competencies in outpatients and basic life support refresher training in October 2015. Data provided showed that only three out of six nurses had completed Ramsay outpatient competencies. One nurse told us that they were not up-to-date with all department/role-specific competencies because the department was so busy and "care comes first". We noted that two nurses had not completed training in pre-operative assessment. The matron told us that one of these staff members did not undertake this activity; the other did and they were waiting for a training date. A recent course in June 2016 had been cancelled.
- In the physiotherapy department only two out of six staff had completed Ramsay physiotherapy competencies and the two staff who had completed them had not had them signed off. All six staff had completed departmental condition-specific competencies but these had not been signed off. Staff in the physiotherapy department however, told us they felt well supported with training and professional development and received in-service training on alternate months. There were also opportunities to access NHS facilities to keep updated.
- All staff administering radiation were appropriately trained to do so. We saw that all staff, including agency staff had completed competency-based training for each piece of equipment.
- Staff did not receive regular supervision or appraisal to ensure their competence was maintained and their learning and development needs were identified. Ramsay policy was for staff to receive annual performance development reviews; however, records showed that not all staff had been appraised in the last 12 months. In outpatients, two out of six staff had not had an appraisal for over two years. In physiotherapy, eight out of eleven staff had not had an appraisal in the last 12 months, although most of these were only a few weeks overdue. However, one staff member had not had an appraisal for three years. In radiology, two out of three staff had not had an appraisal for over two years. Two out of four reception staff were up to date with their appraisal, one was overdue by over two years and one had no information supplied. Two bookings staff were also overdue by two years.
- There were 160 consultants employed under a practising privileges agreement. Practising privileges are granted to medical practitioners by a hospital governing board to allow them to provide patient care and treatment within that hospital, subject to them providing certain evidence of their good character, qualifications, skills and experience and compliance with the terms and conditions of the practising privileges policy. The medical advisory committee reviewed applications for practising privileges and we saw evidence of this in the minutes of their meetings. There was a database maintained to ensure that all practitioners holding practising privileges had received a satisfactory appraisal in their primary place of employment, that they maintained medical indemnity insurance and that they had up-to-date clearance by the Disclosure and Barring Service (DBS). We reviewed five surgeons' records and found all DBS, references, professional registration, occupational health, speciality qualifications were checked and up to date. However, the recording of appraisals did not always reflect the scope of practice the surgeon carried out at the hospital. One file we reviewed contained only a front sheet of an appraisal. We discussed some of our concerns with the

documentation of practising privileges and we were told that due to a change in hospital management the practising privileges policy and procedures were in the process of being updated.

Multidisciplinary working (related to this core service)

- Staff, teams and services mostly worked together to deliver effective care and treatment.
- As part of the justification process to carry out exposure to radiation, the imaging service always attempted to make use of previous images of the same person, even if these had been taken elsewhere. Images brought by patients on compact disc were manually imported to the picture archiving communication system (PACS), and NHS patients had their imaging requested via the electronic imaging portal (which allowed sharing of images between most private and NHS hospitals).
- The radiology manager told us the process for requesting and importing images was quite time consuming as there were a number of security checks to complete to ensure the correct images were being imported for the correct patient.
- The radiology manager told us they were not always informed when outpatients' clinics were planned at weekends or theatre lists required imaging support. However, following a daily huddle meeting during our inspection they commented that it had been useful to hear about anticipated activity levels in theatres and on the ward.

Seven day services

- Outpatients' services were available Monday to Friday and Saturday mornings.
- The imaging department was open Monday to Friday 8.30am to 5.00pm, and provided emergency cover to the wards via an overnight and weekend on-call service, covered by the radiographers.
- Radiologist overnight cover was through a service level arrangement with a nearby NHS trust.
- Pharmacy services were available Monday to Friday only.

Access to information

- The diagnostic imaging department ensured that it met clinical guidance for report turnaround times, by monitoring outstanding reporting on a daily basis. The radiology manager oversaw this and highlighted any images that were waiting with the relevant radiologists. Although we did not see any data to support this, we were told backlogs were not an issue as the number of investigations performed was quite manageable.
- Consultants could access patients' images in the hospital via the hospital's patient archiving and communication system (PACS). However, the diagnostic imaging system did not provide electronic access to images to patients' GPs who received written reports by post.
- Staff in outpatients reported no problems with regard to the availability of information required, such as test results, for outpatient clinics.
- Consultants wrote to GPs following outpatient consultations. We were told this was audited by the hospital but data was not provided to support this.
- In the three months prior to our inspection, there were no cases reported where patients' medical records were not available at their outpatient appointments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a lack of assurance that patients' consent to treatment was sought in accordance with legislation or guidance. Nursing staff in outpatients showed a lack of knowledge and understanding of the requirements of the Mental Health Act 2005 in relation to the gaining of consent for those patients who may lack capacity to make decisions. One nurse in outpatients told us about a young person who had attended outpatients recently who did not have the capacity to consent to care and treatment. They told us that consent had been provided by a carer who accompanied the patient to the clinic. They could not describe what checks had taken place to check that the carer had authority to consent on their behalf.
- Patients were supported to make informed decisions about their care and treatment by the provision of information. There was a range of patient information leaflets relating to surgical and diagnostic procedures which set out the benefits and risks of surgery, what the surgery involved, likely complications, after effects and recovery times.
- We looked at a sample of seven patients' records for patients who had received treatment in the outpatients

department. All of the records showed that written consent had been provided by the patient, who confirmed that the risks and benefits of the procedure had been explained to them.

- In April 2016 the internal Ramsay provider visit had highlighted a lack of evidence of written consent for diagnostic imaging procedures. Action had been taken to rectify this and consent forms were now scanned to form part of the patient record on the diagnostic imaging computer system. The radiology manager told us this system had been in place for approximately three months but had not been audited.
- The hospital conducted quarterly audits of the consent process. Hospital-wide results in September, December 2015 and March 2016 ranged between 85% and 94%.

Are outpatients and diagnostic imaging services caring?

Good

We rated this domain as good because:

- Staff treated people with compassion, kindness, dignity and respect.
- We observed staff interact with patients in a respectful and considerate manner.
- Patient satisfaction survey results showed consistently high levels of satisfaction.
- Staff took steps to protect patients' privacy and dignity, including during physical and intimate examinations and treatment.
- Patients were involved as partners in their care. Patient satisfaction survey results showed that patients were well informed about their care and treatment and knew how and when they would receive test results.

Compassionate care

- Staff treated patients with courtesy, care, and compassion, dignity and respect. In a patient satisfaction survey in the outpatients department in May 2016:
- 100% of respondents said they had enough time to discuss their health problem with their doctor and their nurse.
- 100% of respondents said they were treated with dignity and respect.
- 100% of respondents said they were given privacy when discussing their condition or treatment.

In radiology:

- 100% said the team were friendly and reassuring.
- 100% said they had privacy while changing their clothes.
- Friends and family test results (for NHS patients) were consistently high (98% to 100%) between October 2015 and March 2016. Comments from patients who completed the survey included "really pleasant friendly staff, making the experience so much better" and "made to feel very welcome and comfortable" and "a genuine care for patients from everyone involved".
- We asked patients visiting outpatients, X-ray and physiotherapy departments in the weeks leading up to or inspection, to complete comments cards. We received seven responses, all of which were positive. A relative who accompanied a patient attending the pre-operative assessment clinic described the nurse as "extremely kind, putting us both at ease. What a lovely member of staff". Physiotherapy staff were described as "helpful and encouraging" and considerate and reassuring". Reception staff were described as "polite, welcoming and helpful". X-ray staff were described simply as "excellent".
- We observed reception staff greeting patients in a friendly and courteous manner. Doctors and nurses interacted with patients in a polite, respectful and friendly manner.
- We spoke with three patents, all of whom were happy with the care and attention they had received from all staff. Staff were described as charming, friendly and helpful.
- At times when the outpatient department was busy, patients could be overheard when speaking with the receptionist. A quiet room was available in the outpatients waiting area where private conversations could take place but there were no notices displayed to make patients aware of this facility.
- We observed staff in outpatients and radiology knocking on clinic/treatment room doors before entering. Doors had sliding notices to indicate when they were occupied. Staff drew curtains around examination couches to protect people's dignity.

Requires improvement

Outpatients and diagnostic imaging

- Staff told us that they provided chaperones to accompany patients when intimate examinations were undertaken. There was a notice at the reception desk, which advised patients that they could request a chaperone. There were also notices displayed in clinic rooms. The provider's chaperoning policy which stated that, if for any reason a chaperone could not be provided, the patient should be offered the opportunity to have the procedure or examination postponed. This discussion should be recorded in the patient's notes. Staff in outpatients told us that this situation did not occur and they would always find a member of staff to act as a chaperone, although on occasions this was difficult. In the patient satisfaction survey conducted in March and April 2016 no patients indicated that they had been offered a chaperone during examination or saw a notice. The lack of notices was highlighted in the recent provider's visit and this was rectified. Subsequently, in May 2016, the score was 100%.

Understanding and involvement of patients and those close to them

- Patients were involved as partners in their care.
- In a patient satisfaction survey in April 2016. Sixty four per cent of respondents said they had received copies of letters sent to their GP.
- In a patient satisfaction survey in radiology in May 2016:

- 100% of respondents said the information provided about the examination was useful

- 84.6% of respondents said that they were told how to get their test results.

Emotional support

- Staff told us they understood, and were alert to, signs of anxiety and distress in patients. They told us that patients who needed support were not rushed and were invited to sit in a quiet room if they needed privacy.
- Patients were encouraged to bring relatives or friends to their appointments for support.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated this domain as requires improvement because:

- The hospital had taken few steps to support people in vulnerable circumstances, such as patients living with dementia or patients with a learning disability. Staff in outpatients were not able to describe any examples of support which may be provided to such patients.
- Patient information leaflets relating to surgical procedures did not indicate that they could be made available in languages other than English or other formats, such as large print, braille or easy read. Staff told us they had never been asked for information in other formats and they were not aware of any facility to provide this.
- The complaints system was not well publicised and patients were not offered support with their complaint.
- Patients attending the diagnostic imaging department, who were required to undress, were not offered sufficient privacy while waiting for their treatment.

However,

- Patients mostly received timely access to care and treatment. The hospital consistently met the NHS standard which measures the time that people wait from referral by their GP to consultant-led treatment.
- Outpatients' clinics took place so that, as far as possible, patients were able to access care and treatment a time that suited them. Clinics mostly ran to time and cancellations rarely occurred.
- Premises were mostly appropriate for the services that were planned and delivered. There was ample free car parking, good signage and waiting areas were light, airy and comfortable.

Service planning and delivery to meet the needs of local people

- Services provided reflected the needs of the population and ensured flexibility, choice and continuity of care. The hospital engaged with commissioners and other stakeholders to plan and deliver contracted services based on local requirements. There were plans to provide an outpatient and diagnostic cardiology service in response to high demand for cardiac investigations.
- Premises and facilities were mostly appropriate for the services that were planned and delivered. However, in the diagnostic imaging department, the location of the changing facilities meant that patients who had undressed and were clothed in a dressing gown had to walk through the main waiting room to access the treatment rooms. Staff were aware of this issue and took

steps to preserve patients' privacy while they were waiting, by the use of screens. The issue had also been highlighted during the provider's visit in April 2016. There were plans to reconfigure and extend the diagnostic imaging department and this issue was to be addressed at that time. The reception area in the diagnostic imaging department had recently been reconfigured to create office space so that staff could hold private telephone conversations with patients.

- There was adequate car parking and clear signage to the hospital. In the main reception, there was a large waiting area, with a smaller lounge (premium care lounge) leading from this, for privately funded patients. Both areas were light, airy and furnished with adequate comfortable seating.
- There were toilets, which could be accessed by people who used a wheelchair. Staff told us that facilities were available for nappy changing and for breast-feeding mothers, although there was no information displayed to make people aware of these facilities. There were no play facilities for children. We noted in the hospital's action plan, following a provider visit in April 2016 that toys had been removed from the waiting area due to concerns about processes for cleaning them. Newspapers and magazines were provided but there was little patient information displayed.
- In the main waiting area drinking water was available from a dispenser. In the premium care lounge, hot drinks were also available. We asked staff about the reason for segregating NHS and privately funded patients. They were unsure about the rationale for this. One staff member told us they felt embarrassed when they had to explain to NHS patients that hot drinks were only available to privately funded patients. Another staff member told us if a patient asked they would provide them with a hot drink. They told us they had made a suggestion to the senior management team that a drinks machine should be made available in the main waiting area. They were not sure if this was being considered. We asked the general manager, who told us that it was Ramsay Health Care policy to provide a separate waiting area with access to hot drinks for privately funded patients. They told us there were no plans to change the facilities because there were concerns about spillages. They told us that if patients in the main waiting area requested a hot drink they would be provided with one.

Access and flow

- Patients received timely access to assessment, care and treatment. The NHS Constitution sets out that NHS patients should wait no longer than 18 weeks from GP referral to consultant-led treatment. This standard is known as referral to treatment (RTT). The provider achieved 100% against this standard during the reporting period (April 2015 to March 2016).
- In diagnostic imaging, during the same reporting period, there were:
  - Six patients who waited six weeks or longer from referral for the diagnostic test.
  - For magnetic resonance imaging (MRI), 4.8% (two) patients waited six weeks or longer from referral for the diagnostic test in March 2016.
  - For computed tomography (CT), 25% (one) of patients waited six weeks or longer from referral for the diagnostic test in March 2016.
  - For non-obstetric ultrasound, 100% (one) of patients in May 2015 and 20% (two) patients in March 2016 waited six weeks or longer from referral for the diagnostic test.
- Outpatients' clinics took place from 8.30am to 8.30pm from Monday to Friday and on alternate Saturday mornings so that, as far as possible, patients could access care and treatment at a time which suited them. Physiotherapists organised shifts to cover a long day to allow for flexibility of appointments.
- In a patient satisfaction survey in May 2016, 55% of respondents said they had a choice of appointment time. Eighty-nine per cent of respondents said they were seen on time or within 15 minutes of their appointment time. Staff told us that clinics mostly ran on time although sometimes consultants ran late. If this was the case, they told us that this would be explained to patients. During our visit we heard the reception staff in diagnostic imaging informing a patient, who had enquired about their waiting time, that there were several patients in front of them. They could not tell them how long they would have to wait as the doctor had not yet arrived to start the clinic.
- Reception staff told us that sometimes patients queued to be checked in at reception. At busy times this meant that calls to the hospital switchboard were not answered promptly.

- Staff told us that care and treatment was only cancelled when absolutely necessary; however the hospital was unable to provide data to support this. Staff told us cancellations were explained to patients and appointments re-booked as soon as possible.
- The radiology manager told us there had been some problems with voice recognition software following an upgrade of the picture archiving and communication system (PACS), and did not feel able to support the radiologists as they did not use the software. This had the potential to slow down reporting of images. Problems had to be logged through the helpline for the PACS provider, which staff said was not very responsive, and was frustrating to use.

Meeting people's individual needs

- The hospital had taken few steps to support people in vulnerable circumstances, such as patients living with dementia or patients with a learning disability. Staff in outpatients were not able to describe any examples of support which may be provided to such patients. However a nurse told us about a deaf patient who was due to attend a pre-operative assessment clinic. The hospital had made arrangements for a signer to support the patients at their appointment and a longer appointment had been arranged in recognition of the communication difficulties which may arise.
- We were provided with a sample of patient information leaflets relating to surgical procedures. These documents did not indicate that they could be made available in languages other than English or other formats, such as large print, braille or easy read. Staff told us they had never been asked for information in other formats and they were not aware of any facility to provide this. There was access to a telephone translation service and there was a poster displayed in the nurses' office with their contact details but this service was not publicised to patients.

Learning from complaints and concerns

- People's complaints were listened to and responded to in order to improve the quality of care. However, the hospital's complaints procedure was not well publicised. We saw no posters displayed advising people how they could raise concerns or make a complaint. The Winfield Hospital website invited people to provide feedback and there were links to enable patients to do so but the complaints procedure was not explained.
- On the first day of our inspection we saw there were leaflets on the reception desk which outlined the complaints procedure for private patients. This included reference to the Independent External Adjudication Secretariat. This is an independent body, which may investigate complaints where a complaint has not been resolved by the hospital concerned. There were no complaints leaflets which were applicable to NHS patients and which included the contact details for the Parliamentary and Health Service Ombudsman. When we queried this with the general manager it was found that leaflets, which had previously been available, had been removed by staff because they were overdue for review (July 2016). On the second day of our inspection NHS complaints leaflets were made available.
- Neither of the complaints leaflets made any reference to support which may be provided to patients during the complaints process or any reassurance that their care and treatment would not be adversely affected by the fact that they had complained.
- Staff told us they were encouraged to escalate dissatisfaction as soon as they became aware of it. They told us they would try to arrange for patients to speak with the matron or the general manager.
- Staff in outpatients told us that the department received few complaints. They felt they would only be made aware of a complaint if they were directly involved in it. Staff were unable to describe any complaints or any improvements which had been made as a result of complaints.

The general manager told us that following a number of complaints regarding billing issues in the imaging department, whereby the consultants were collecting 'shortfall' fees from insured patients, she had met with the consultant radiologists to explain that this practice had to stop. The general manager had also apologised to the patients involved and reassured them they would not be expected to make up consultant shortfalls.

- Complaints were managed by the general manager and the matron. Complainants were invited to meet with the general manager or the matron to discuss their

concerns. The senior management team told us that complaints and lessons learned were discussed at heads of department meetings, senior management meetings and relevant departmental meetings.

- The service aimed to acknowledge all complaints within 48 hours and respond fully within 20 days. If this was not achievable, a holding letter was sent. We reviewed four complaints. All had been acknowledged within two days, in accordance with Ramsay Health Care's policy. Complaints were investigated thoroughly and patients received a comprehensive response and an apology where appropriate. Some investigations took longer than 20 days but complainants were kept informed about the delay.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We have rated this domain as requires improvement because:

- Governance and reporting processes were not fully effective to ensure effective communication 'from ward to board' and from 'board to ward'.
- There was insufficient evidence that managers had oversight of all performance, including risks to quality and safety. The recent provider visit had highlighted weakness in governance processes which still needed to be improved. For example, there was insufficient oversight of mandatory staff training and little evidence that audits were consistently taking place as planned or learning was taking place following these audits.
- The management team had suffered from a period of instability with a significant number of management changes. There had been a difficult transition period while managers settled in. Staff meetings did not occur regularly and staff consequently felt they did not a have a voice.
- The recent staff survey had yielded a disappointing response and highlighted some worrying themes. Staff engagement and involvement needed to improve to address issues which affected staff morale and make them feel more valued.

However,

- The hospital had a clear strategy and had developed a vision statement with involvement and engagement from staff. Not all staff felt engaged in this and not all staff could articulate the vision statement but they all expressed with passion their desire to provide the best patient-centred care.
- The senior management team was now established and from October 2016, all heads off department posts would be filled.
- The senior management team were respected; in recent months, they had become more visible and most staff told us they were accessible and supportive.
- The senior management team were working on a new staff engagement strategy, responding to the themes highlighted in the staff survey. Daily huddles had been introduced to help inter-departmental working and head of departments were team building and looking at ways to better support each other and work cohesively.
- Most staff told us they enjoyed working at Winfield Hospital. They cited teamwork and camaraderie as the best thing about working there.
- The hospital had recently appointed a quality lead who would have oversight of the clinical audit programme.

Vision and strategy for this this core service

- There was a clear vision and a quality strategy to deliver good quality patient care.
- The Ramsay Health Care UK group had a set of values, known as "the Ramsay Way, supported by a range of behaviours. The hospital's vision was "to provide superior patient centred care with compassion, expertise and pride at all levels. Quality care is our priority and we aim to provide this by embracing clinical innovations, inspiring our staff and above all caring for those that depend on us."
- The senior management team told us that staff had been engaged in developing the hospital's vision. Heads of department had consulted with their staff, who responded with suggestions based on the six C's (care, compassion, competence, communication, courage, commitment) and the Ramsay values. Staff in the physiotherapy department articulated the Ramsay Way and the hospital's vision, whereas staff in the outpatients department did not seem to be engaged with this, although they demonstrated commitment to providing excellent patient-centred care. In the 2016

staff survey 98% of respondents agreed with the statements: "I always work for the best interests of the patients and colleagues" and I understand the impact that my work has on delivering excellent patient care."

Governance, risk management and quality measurement for this core service

- The hospital's quality strategy set out the key components of governance by which the management team would assure the provision of a quality service. These were clinical governance, patient feedback, staff engagement, trained and competent workforce, accountability and support.
- There was a committee structure within the hospital, with reporting lines to the senior management team, as well as corporate committees and the Ramsay Health Care Board. This structure was designed to ensure effective communication from ward to board and management oversight of all performance indicators and risks to performance. Committees included clinical governance, infection prevention and control, health and safety and medical advisory committees. Heads of departments also met monthly and they were expected to hold regular departmental meetings. As discussed further below, under leadership/ culture of service, departmental meetings were not taking place regularly in outpatients or diagnostic imaging. The senior management team had recognised that communication needed to improve to ensure there was learning from incidents, complaints and audit. Our judgement was that the governance arrangements needed to be strengthened to ensure that risks were better understood and managers held to account for managing areas of risk. A quality lead had recently been appointed to support managers in this process.
- There were standardised meeting agendas templates to ensure consistency and that all important areas affecting performance and quality were regularly discussed. However, we saw from the minutes of clinical governance meetings held in August, and November 2015 and February and May 2016 that items including clinical performance, patient satisfaction, audit programme, and risk register, were not discussed.
- Compliance with mandatory training was a standing item on the monthly clinical governance report compiled by the matron. In April 2016 no training data was reported. It was recorded that a new training lead was in post and that training data was not accurate.
- The hospital received annual provider visits, which were carried out by a team of peers and managers from the Ramsay Health group. The last visit had taken place in April 2016, and had been requested by the general manager who was new in post, to provide a baseline from which to move forward. The inspection team, made up of managers from head office and peers, had inspected services using CQC's five questions; are services safe, effective, caring, responsive and well led? An action plan had been developed following the publication of the report and improvements were in progress. Overall, the findings of the provider visit highlighted that governance processes and management oversight of performance required improvement.
- Risk registers were not held at department or hospital level. There was a corporate risk register but we saw little evidence of meaningful discussion of local risks and accountability for managing local risks or escalating them was not clear. There was a range of risks assessments relating to the work place and working practices in outpatients. These had been completed in November 2015 by the previous outpatients' manager but had not been signed off. Staff were not able to describe the risks to patient quality and safety within their department. Staff in the diagnostic imaging department told us they had completed risk assessments and the primary risks relating to their department were the lack of a height-adjustable table, privacy and dignity in the waiting area and the age and reliability of theatre screening equipment. There were plans in place to address these risks.
- Engagement with the consultant body was via the medical advisory committee (MAC). The MAC represented the medical practitioners who practised at the hospital via specialty representatives elected to the committee. The hospital manager told us that attendance at the MAC since they took up their post had been variable. A consultant told us during our inspection that they did not receive regular communications from the MAC.

Leadership / culture of service

- The senior management team (SMT) consisted of the general manager, who had been in post since November 2015, matron who had been in post since 2010, the finance manager, who had been in post for 18 months and the recently appointed operations manager.

Requires improvement

Outpatients and diagnostic imaging

- There were mixed views about the visibility of the SMT. Some staff told us the matron was visible, accessible and supportive; others disagreed. There were also mixed views about the visibility of the general manager, although staff acknowledged that this was improving. The matron had recently moved offices and they were now based in the outpatients department. The general manager was also planning to move their office to 'front of house' so they would be more accessible.
- The SMT told us that they had an 'open door policy' and that they made themselves available to attend departmental meetings on request. The hospital had recently introduced a hospital-wide 'huddle' meeting, whereby representatives from all departments met to share immediate updates on, activity, staffing, incidents, and social news. This forum also provided an opportunity for departments to support each other and, when applicable, re-distribute resources. Staff on the whole had welcomed this forum and commented that it had increased the visibility of SMT members.
- We attended a huddle meeting during our inspection. The meeting was informal and lasted approximately ten minutes. Nine departments were represented and the matron also attended. Outpatients and physiotherapy departments were not represented. Each department representative provided a summary of activity and staffing. The pharmacist advised colleagues about the unavailability of a pharmaceutical item. The radiology manager informed colleagues about a new staff member who would be joining the team the following week. Departments had adopted different ways of feeding back news from the huddle. In the physiotherapy department a portable white board was used, in the radiology department a communication books had been introduced and in outpatients, a whiteboard in the nurses' office was used.
- Staff did not always feel respected and valued. Some disaffected staff in outpatients and physiotherapy felt they were not listened to or well supported by the senior management team (SMT). This feedback was consistent with feedback in the 2015 staff survey in which only 31% of respondents agreed with the statement "The senior management team take the views and opinions of staff seriously". The survey also highlighted that only 43% of respondents agreed that they received recognition from those they worked with for a job well done and only 45% indicated that they we encouraged to use their ideas and suggestions to deliver an excellent service.
- The physiotherapy team felt there was a lack of understanding in respect of their roles and the way they worked. The team was short of staff and had been unable to recruit enough bank staff consistently to fill the shortfall. They reported that they had not been permitted to employ agency staff because it was felt that this would be detrimental to continuity of patient care. Part time staff had increased their hours and the physiotherapy manager regularly worked additional hours. The general manger had recently attended a departmental meeting and staff had had the opportunity to raise their concerns with regard to staffing. A new physiotherapy assistant had recently been appointed and was due to start soon.
- The outpatients' team told us they had repeatedly raised their concerns about the way in which the pre-operative assessment function was run but did not feel that their concerns had been listened to. Reception staff told us that they had raised concerns about not being able to offer hot drinks to NHS patients in the main waiting area, whilst patients in the premium care lounge had access to hot drinks. Again they felt their concerns were not listened to.
- Below the senior management team, the service had seen a significant number of changes in management over the last twelve months. At the time of our visit, the head of department position in outpatients had been vacant for a number of months, although a new appointment had just been made and the post holder was due to commence in October 2016. The previous post holder had also had lengthy periods of absence prior to them leaving and this had caused instability in the department for some eighteen months. One staff member told us they had five different outpatients' managers in a period of seven years; another told us they had had eight managers in 12 years. A senior staff nurse had temporarily assumed some of the post holder's managerial responsibilities. They did not attend monthly heads of department meetings, although they had been invited. No departmental staff meetings had taken place for three months. Communication took place informally by staff working alongside one another and messages were relayed via a whiteboard in the nurses' office. Staff told us it was difficult to fit staff meetings into their schedule; they felt that communication suffered because there was no formal staff forum.

Requires improvement

Outpatients and diagnostic imaging

- In diagnostic imaging, the radiology manager had been in post since November 2015. This department had also suffered from a period of instability and during the provider visit staff highlighted concerns about poor communication. The radiology manager acknowledged that there was still work to do to improve communication in the department. Staff meetings had not taken place for some time, although a communication book was now in place in the department. Staff shortage had been the primary reason for a lack of formal communication. The radiology manager had spent a significant amount of time supporting imaging in theatres and managerial duties had suffered as a result. Staff fully understood and acknowledged this. They described the manager as accessible and supportive. Staff respected and admired him for driving forward change and improvement in the department, as well as improving relationships with other departments and the consultants. The radiology manager felt they had been well supported by the SMT and the regional radiology lead during a difficult period of transition. When they took up the post, the department was under staffed and there were issues with accommodation and equipment. Staffing had been improved by the appointment of a health care assistant and the employment of agency radiographers, pending the appointment of a permanent radiographer. The radiology manager told us "with a full complement of staff I can start moving forward, instead of fire fighting". Offices had also been built to provide space for staff to make private telephone calls. Plans had also been agreed to further extend and improve the department and to replace equipment.
- In the physiotherapy department there was more stability and staff felt well supported by the physiotherapy manager, who they said communicated well with the team. Regular staff meetings took place.
- The reception team, consisting of five staff were led on a day-to-day basis by a team leader who reported to the hospital's newly appointed administration manager, who had been in post for just one month at the time of our inspection. The team had been without a manager from February to June 2016, which they described as a difficult time, although they had received support from the matron.
- Despite the concerns described above, most staff told us they enjoyed working at the Winfield Hospital. Team work and camaraderie were cited some of the best things about working there. Staff in outpatients told us there were generally good relationships with consultants, although there were occasional "grumbles" from consultants about nurse staffing levels. Staff said they would refer consultants to the matron in these circumstances. A consultant told us during our inspection that nursing staff were friendly, helpful and efficient and that their secretary was "amazing".
- Staff turnover rates for nurses working in the outpatients department were above the average when compared to other independent acute hospitals, in the reporting period (April 2015 to March 2016). However, this was in the context of a small department, employing only six staff. There were two leavers in the reporting period, of which one had remained employed on a temporary (bank) contract.

Public engagement

- Inpatients were invited to complete a satisfaction survey ('We value your opinion') which asked specific questions about pain relief, catering and staff. These questionnaires were available on the hospital's main reception desk but staff told us they were not routinely given to patients attending outpatients' clinics. They did not know the reason for this. They told us that NHS patients were given a friends and family questionnaire. This asked patients whether they would recommend the service to friends and family.
- 'We value your opinion' questionnaires were analysed by a third party organisation that produced regular reports. The service also received 'hot alerts' on a weekly basis - these were either negative or positive responses. We were told that if patients indicated that they wished to receive a response, and provided their details they would be written to. The SMT told us that they had recently invited patients to join a patient focus group.
- We were told that patient feedback was shared with staff via staff meetings, the daily huddle and the staff newsletter. We saw evidence of this in the newsletter and in the minutes of physiotherapy staff meetings. The physiotherapy manager explained to us that there was limited feedback received in relation to physiotherapy treatment and they would like to develop their own questionnaire

Staff engagement

Requires improvement

Outpatients and diagnostic imaging

- Staff engagement was highlighted in the 2015 staff survey as an area that required improvement. The senior management team told us that in response to staff feedback they had developed a revised staff engagement plan. Daily huddles had been introduced a simple way of communicating important information and encouraging teams to work together. In the staff canteen there was a staff noticeboard. Information displayed included the Being Open Policy, friends and family survey results, the results of the 2015 staff survey and staff vacancies. There was also a suggestion box in the staff canteen. The SMT told us they were developing a staff engagement plan and they were planning to conduct another staff survey in six months' time.

Equality and Diversity

- The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers and independent acute providers that deliver £200k or more of NHS-funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.
- There was a corporate 'Equality Duty and Actions Report 2016' which provided information about equality in Ramsay UK's workforce. This included a set of objectives to address identified equality issues and set out a commitment to produce an Equality and Diversity Action Plan for 2016-18, to be published in June 2016. There was no report or action plan for the hospital.

Innovation, improvement and sustainability

- Following discussion with commissioners, there were plans to provide a cardiology service, to include outpatient and diagnostic services.
- There were detailed plans to remodel and update the diagnostic imaging department. This entailed the utilisation of existing space to improve the patient experience (addressing the privacy and dignity issues in the waiting room) alongside a capital replacement plan to replace, upgrade or purchase new equipment, including a rise and fall imaging table, a new image intensifier and, in partnership with another provider, the installation of a permanent MRI scanner.
- There was a robust, realistic strategy for achieving the priorities set for the diagnostic imaging service, and the radiology manager had prioritised the replacement of equipment based on the age, reliability and usage. This also included decommissioning a dental x-ray machine which there was no demand for.
- The radiology manager had also secured funding for another member of staff, which staff said was "amazing", and had boosted morale in the department.
- In response to the 2015 staff survey, the heads of department had attended a two day leadership and team building course. Managers spoke very positively about the benefits if this course, where managers had explored ways of better supporting each other and encouraging their teams to work together. Following this, heads of departments had agreed to meet informally, in addition to their monthly heads of department meetings.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that all medicines held within the diagnostic imaging department, are stored correctly, in accordance with manufacturers' guidance.
- Ensure there are robust systems in place to track medicines and prescription pads in outpatients in order to prevent theft or misuse.
- Take action to ensure that patient records are legible accurate, comprehensive and contemporaneous and completed by all members of the multidisciplinary team.
- Ensure that consent for medical photography is obtained and clearly documented in the patient record. Ensure that medical photographs are stored safely and securely in line with policy
- Ensure compliance to the surgical safety checklist and audit appropriately to provide assurances
- Ensure that the duty of candour is implemented in a timely manner for those incidents where regulation 20 applies.
- The provider must ensure that audits provide the evidence that the governance systems are effective.
- Ensure that all equipment such as commodes are properly decontaminated.
- Ensure systems are in place to maintain an overview of the compliance data with cleaning standards.
- Ensure that reporting and assurance from audits completed on the ward and in theatres provide the evidence that the governance systems are effective.
- Ensure meetings follow the corporate standard agenda and that all items are discussed and recorded with sufficient detail to provide assurance and actions.

Action the provider SHOULD take to improve

- Consider the removal of carpets in patient's rooms to ensure adequate cleaning.
- Consider remedial improvements to the dirty utility walls.
- Ensure better attendance of medical advisory committee meetings.
- Ensure that staff consistently receive feedback about adverse incidents to ensure learning and improvement.
- Proceed with planned replacement of the imaging table with a height-adjustable table to reduce the risk of falls and staff injury.
- Take steps to support people in vulnerable circumstances, such as patients living with dementia or patients with a learning disability.
- Review patient information leaflets and ensure that information is made available in languages other than English and other formats, such as large print, braille or easy read.
- Take steps to better publicise the complaints system to patients, inform patients of sources of support with their complaint and reassure them that their care and treatment will not be affected by the fact that they have made a complaint.
- Proceed with planned works to improve the privacy and dignity of patients who are required to undress in the diagnostic imaging department.
- Ensure management oversight of mandatory training compliance and take steps to improve compliance.
- Continue to develop staff engagement, explore reasons for poor staff survey results and take actions to address these.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17(1).Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** **17(2).Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—** 1. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); 2. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 3. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; • **There was a lack of robust oversight and adherence to the corporate clinical governance process as there were several examples where required items were not discussed at meetings. These included patient satisfaction, audit and the risk register.** • **The hospital on identifying risks within the surgical safety checklist did not introduce measures in a timely manner to minimise further risk nor were they monitored appropriately.** • **The hospital did not have overall assurances that the audits of cleanliness undertaken were feedback routinely.**

This section is primarily information for the provider

Requirement notices

- The hospital records kept were not always fit for purpose, legible, accurate or complete. Consent for and storage of medical photography did not always support the confidentiality of the people using the service and we could not be assured they were held securely.
- There was insufficient oversight of staff compliance with mandatory training.
- There were inadequate control systems in place to ensure tracking of prescription pads in outpatients.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour 20 (1). Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. 20 (2). As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must— 1. notify the relevant person that the incident has occurred in accordance with paragraph (3), and 2. provide reasonable support to the relevant person in relation to the incident, including when giving such notification. 3.The notification to be given under paragraph (2)(a) must— (c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate, Documentation after a never event was not robust and did not provide an accurate record of conversations carried out with the patient after the event.