Oaks Hospital

Quality Report

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Date of inspection visit: 20 December 2016
Date of publication: 10/03/2017

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

Ratings

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

Overall summary

Oaks Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 57 bedrooms including three twin-bedded rooms all with en-suite facilities beds and an 11 bay ambulatory unit which caters for patients undergoing day surgery procedures and endoscopy.

Facilities include four operating theatres, outpatient and diagnostic facilities. Outpatient facilities include two fully equipped ophthalmology suites, fourteen consultant rooms and two minor treatment rooms.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. Services for children and young people were suspended and under review at the time of

Summary of findings

inspection. Oaks Hospital had treated two oncology patients between July 2015 and June 2016. We inspected surgery services and outpatients and diagnostic imaging services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 20 December 2016 along with an unannounced visit to the hospital on 29 December 2016.

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

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

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

Services we rate

We rated this hospital as good overall.

We found good practice in surgery:

- Staff knew how to report incidents using the electronic reporting database. Incidents were investigated and learning shared.
- Medicines and controlled drugs were stored and monitored appropriately.
- The hospital was visibly clean and tidy and equipment was maintained and serviced.
- The hospital used the World Health Organisation five steps to safer surgery checklist and we found through observation and review of records that this was followed correctly. Audit data provided by the hospital showed 100% compliance with five steps to safer surgery in February and May 2016.
- One-hundred per cent of staff had completed level two safeguarding training.
- There was a comprehensive audit programme in place to monitor compliance with best practice and hospital policies.
- The hospital had Joint Advisory Group (JAG) accreditation for endoscopy services.
- We observed staff interacting with patients in a kind and caring manner. Patients told us that staff were kind, compassionate and kept them informed about their care. Figures for the Friends and Family Test between May and August 2016 showed that 93% to 100% of patients who responded would recommend the service to friends and family.
- On average over 90% of NHS patients were admitted for treatment within 18 weeks of referral.
- The hospital cancelled only six operations during the reporting period and all were offered another appointment within 28 days.
- There was a robust complaints process and learning from complaints was shared with staff.
- There was a clear governance process in place with clear lines of communication between staff, heads of department, senior management team and the medical advisory committee (MAC).
- The general manager was respected by all staff and the MAC chair and all were positive about the impact they had had on the hospital.

We found areas of practice that required improvement in surgery:

- Immediate life support training rates were below the hospital target for both theatre and ward staff. Only two members of the recovery team plus the resident medical officer and matron had completed advanced life support training.
- There was no clearly defined escalation process for a deteriorating patient following chemotherapy. Oncology patient records held on site did not contain clearly defined drug protocols or a copy of the patient consent.
- We found that a number of consultants had not provided their up to date appraisal as per the hospital policy in order to maintain their practising privileges.
- The hospital did not specifically monitor fasting times so were unable to assess if patients were fasted for extended periods if their operation was delayed.
- Risk management processes were not fully embedded. The lack of consent forms and of triage and assessment of the deteriorating oncology patient had not been recognised as a risk.

Summary of findings

We found good practice in outpatients and diagnostic imaging:

- There had been no never events or serious incidents within outpatient and diagnostic imaging services between July 2015 and June 2016. Incidents were fully investigated and lessons were learned and shared.
- Areas we visited were visibly clean and we saw good infection control techniques, which were in line with policy and national guidance. Equipment had up to date maintenance and recorded checks.
- All outpatients and diagnostic imaging staff had completed training in both adult and children's safeguarding to level two and staff we spoke to understood the principles of safeguarding.
- Medicines and controlled drugs were stored and monitored appropriately.
- Policies were up-to-date, version controlled and referenced national guidance.
- Staff had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguarding and the staff we spoke to were able to demonstrate an understanding of relevant guidance.
- Friends and Family Test results were high; between January and June 2016 an average of 98% of patients that responded would recommend the hospital to their family and friends. Patients provided consistently positive feedback about the care they had received and we observed positive interactions between patients and staff.
- The hospital met the target of 92% of NHS funded patients on incomplete pathways waiting 18 weeks or less from time of referral in the reporting period July 2015 to June 2016.
- Above 95% of NHS funded patients started non-admitted treatment within 18 weeks of referral in the same reporting period.
- The hospital had no patients waiting six weeks or longer from referral for the magnetic resonance imaging, computerised tomography or non-obstetric ultrasound diagnostic test.
- Complaints were handled in line with policy. We saw that lessons were learnt and shared. Improvements were made to the outpatient service as a result.
- Outpatients had good leadership. Staff described the senior team as approachable and supportive. There was a culture of openness and transparency.
- There was a clear governance structure. The hospital risk register contained risks which matched concerns identified by staff.

We found areas of practice that required improvement in outpatients and diagnostic imaging:

- Resuscitation equipment such as nasopharyngeal airways and intubation blades had open packaging. This was escalated and addressed immediately.
- Mandatory training figures were below the hospital target. However, the staff who were not up to date were bank (temporary) staff who had not recently worked at the hospital.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led. The general manager had increased the focus on risk management since their appointment in August 2016. They had identified areas of improvement for the children's service which had prompted the temporary suspension until security measures, policies and training had been put in place. However, there were areas of risk within oncology that identified the need for increased oversight and a regular effective review of those services that had low patients numbers, to ensure patient safety and staff competency was maintained. The team were responsive throughout, responded to concerns raised, and took actions to implement changes to reduce risk and increase patient safety.
Outpatients and diagnostic imaging	Good 	Outpatients and diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, caring, responsive and well-led. We did not rate the service for being effective.

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Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Oaks Hospital

Oaks Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital opened in 1994. It is a private hospital in Colchester, Essex. The hospital primarily serves the communities of Essex. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 2 August 2016. At the time of the inspection, the general manager had been in post for five months having transferred from another hospital within the Ramsay Health Care group.

The hospital provides a range of services including outpatient consultation, outpatient procedures, investigations and diagnostics, surgery and follow up care. The specialties include orthopaedic surgery, ophthalmology, endoscopy, urology, spinal, pain management, dermatology, neurology, ear, nose and throat (ENT), dental, general, vascular, gynaecology, cardiology, oncology, breast and laparoscopic surgery.

The hospital was previously inspected on 13 November 2013 and was meeting all standards of quality and safety it was inspected against. There are no compliance actions or enforcement notices associated with this service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on Tuesday 20 December 2016, along with an unannounced visit to the hospital on Thursday 29 December 2016.

Our inspection team

The team that inspected the service comprised a CQC lead inspection manager,one other CQC inspection manager, three other CQC inspectors, and a specialist advisor with expertise in oral and maxillofacial surgery.

Information about Oaks Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited the ward, theatres, outpatients and diagnostic areas and the ambulatory units. We spoke with 25 staff including; registered nurses, health care assistants, allied health care professionals, reception and administration staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and reviewed 12 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 8,849 inpatient and day case episodes of care recorded at the hospital; of these 66% were NHS funded and 34% were other funded.
- 13% of all NHS funded patients and 25% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 47,677 outpatient total attendances in the reporting period (July 2015 to June 2016); of these 42% were NHS funded and 58% were other funded.

140 doctors worked at the hospital under practising privileges. One regular resident medical officer (RMO)

Summary of this inspection

worked on a seven day on / seven days off, 24 hour rota. There were 33.7 whole time equivalent employed registered nurses, 25.1 whole time equivalent employed operating department practitioners (ODP) and healthcare assistants and 49.8 whole time equivalent other hospital staff employed. The accountable officer for controlled drugs (CDs) is the matron.

Track record on safety:

In the reporting period July 2015 to June 2016 the hospital reported:

- No never events
- 164 clinical incidents (112 no harm, 42 low harm, 10 moderate harm, 0 severe harm, 0 death).
- Two serious injuries.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive Staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.difficile)
- No incidences of hospital acquired E-Coli

Services accredited by a national body:

- Endoscopy (Joint Advisory Group accreditation) – reaccredited in December 2015
- BUPA Accredited Breast Care Centre
- BUPA Accredited Bowel Care Centre

Services provided at the hospital that are outsourced under service level agreement:

- Decontamination services
- Emergency blood services
- Histopathology services
- Medical physics
- MRI/CT mobile
- Pathology services
- Pharmacy
- Resident Medical Officer (RMO
- Tissue fertility services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There had been no never events at the hospital between July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital reported 164 clinical incidents between July 2015 and June 2016, which is lower than the rate of other independent acute providers for which we hold this type of data.
- Staff knew how to report incidents using the electronic reporting database. Incidents were appropriately investigated, with lessons learnt and improvements made as a result. We saw evidence that learning was shared with staff. Staff we spoke to understood the principles of duty of candour.
- Areas we visited were visibly clean and we observed appropriate hand sanitation and use of personal protective equipment. Staff adhered to 'bare below the elbows' policy. The hospital had no reported incidents of MRSA, MSSA (Meticillin-sensitive Staphylococcus aureus), E-coli or Clostridium difficile between July 2015 and June 2016.
- Equipment had undergone up to date maintenance and checks.
- Medicines and controlled drugs were stored and monitored appropriately.
- Medical records audits completed in January and April 2016 showed 98% compliance.
- One hundred per cent of staff had completed level two safeguarding training. No safeguarding concerns were reported to CQC between July 2015 and June 2016.

However,

- Mandatory training levels in outpatients (67.16%) and diagnostic imaging (62.07%) were below the hospital's target (85%). However, the staff who were not up to date were bank staff who had not recently worked at the hospital.
- Immediate life support training rates were below the hospital target for both theatre and ward staff. Only two members of the recovery team plus the resident medical officer (RMO) and matron had completed advanced life support (ALS) training.

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- There was no clearly defined escalation process for a deteriorating patient following chemotherapy. Oncology patient records held on site did not contain clearly defined drug protocols or a copy of the patient consent.

Are services effective?

Good

We rated effective as good because:

- Staff had access to comprehensive policy documents which referred to national guidelines and best practice.
- Pain was appropriately and regularly assessed using pain assessment tools. We saw evidence that staff had responded appropriately to patients' pain.
- The hospital undertook a range of regular local audits, which included medicines management, nutrition and hydration and hand hygiene. The hospital reported that they were benchmarked against other hospitals in the group.
- The hospital had Joint Advisory Group (JAG) accreditation for endoscopy services.
- The hospital participated in Patient Reported Outcome Measures (PROMs) for NHS patients and improvements were in line with or slightly better than the England average.
- Rates of unplanned transfer and readmission were not high when compared to other independent health care providers that we hold information for.

However,

- The hospital did not monitor or audit patient fasting times. This meant that the hospital were not able to assess whether patients were fasted for an extended period whilst waiting for surgery.
- Nutrition and hydration audits showed a low rate of compliance. The results for December 2015 were 46%, March 2016, 69% and June 2016, 56%. However, the most recent audit in December 2016 showed an improvement to 90% compliance.
- We found that a number of consultants had not provided their up to date appraisal as per the hospital policy in order to maintain their practicing privileges.

Are services caring?

Good

We rated caring as good because:

- Results for the NHS Friends and Family Test during the reporting period were consistently high, with over 90% of patients who responded stating that they would recommend the service to their friends and family.

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- The hospital's patient survey results from October 2016 showed that 95.1% of patients who responded were likely to recommend the hospital, that 98% said they were given privacy to discuss concerns and 97.1% said they felt involved in the decisions about their care and treatment.
- We observed interactions between staff and patients that were friendly, respectful and supportive.
- Patients told us that staff were kind, compassionate and that they were kept informed about their care.

Are services responsive?

Good

We rated responsive as good because:

- Patients were offered flexibility and choice for appointments and when arranging admission to the hospital.
- On average over 90% of NHS patients were admitted for treatment within 18 weeks of referral.
- The hospital had no patients waiting six weeks or longer from referral for the magnetic resonance imaging, computerised tomography or non-obstetric ultrasound diagnostic test.
- The hospital cancelled only six operations during the reporting period. This was low when compared to other independent health providers that we hold this information for. All six were offered another appointment within 28 days of the cancelled appointment.
- The hospital had a robust complaints process and learning from complaints was shared with staff.
- The service made adjustments to meet the needs of patients with complex or individual needs. For example, there was access to a translation service, facilities were accessible for wheelchair users, there was access to equipment specifically for bariatric patients and a hearing loop was available in reception areas. The hospital also had provision for carers and relatives to stay with patients for support if required.

Are services well-led?

Good

We rated well-led as good because:

- There was a clear governance process in place with clear lines of communication between staff, heads of department, senior management team and the MAC.
- The general manager was respected by all staff and the MAC chair and all were positive about the impact they had had on the hospital.
- The hospital had a number of processes in place to engage with and gain feedback from patients and staff.

However,

Summary of this inspection

- Risk management processes were not fully embedded. The senior team had identified areas of improvement for the childrens service which had prompted the temporary suspension until security measures, policies and training had been put in place. However, the risk of lack of consent forms and the lack of triage and assessment of the deteriorating oncology patient had not been recognised as a risk. This identified the need for increased oversight and a regular effective review of those services that had low patients numbers to ensure patient safety and staff competency was maintained.
- There was low morale amongst theatre staff due to staffing levels and working hours. This was on the risk register and the senior management team reported that they were working with the theatre team to improve morale.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

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

Incidents

- Surgery services had no never events during the reporting period (July 2015 to June 2016). Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital reported two serious incidents (SI's) in the reporting period July 2015 to June 2016. This number of SI's is not high when compared to a group of independent hospitals which submitted performance data to CQC.
- The hospital had no recorded deaths between July 2015 and June 2016.
- The hospital reported 164 clinical incidents between July 2015 to June 2016, of which 56% (92) occurred in surgery or inpatients. There were 59 non-clinical incidents during the same period. Of these, 11 occurred in surgery or inpatients. The rate of clinical incidents was lower than the rate of other independent acute providers we hold this type of data for. The senior team were aware that hospital incident reporting was lower in comparison and were encouraging staff to report incidents.
- Incidents were reported using an electronic reporting system which all staff had access to. Staff were aware of their responsibilities to raise concerns and could describe how and when to report incidents. We spoke to two members of staff who confirmed that they knew how to report an incident and were able to show us the process on the computer system.
- We saw a copy of a root cause analysis investigation carried out after a clinical incident and saw that it was completed in full and learning was demonstrated and an action plan was in place.
- We spoke with the theatre manager and ward manager about incident reporting and both confirmed that staff were encouraged to report incidents. The ward manager confirmed that since October 2016 formal ward meetings had been taking place and incidents were a standing agenda item. The hospital also confirmed that theatre stand up meetings were now happening regularly following the return of the theatre manager after a period of sickness
- Feedback and learning from incidents were shared at weekly stand up meetings and also communicated via the ward newsletter. We reviewed a range of minutes that identified incident discussions. However, learnings were not clearly recorded in the theatre stand-up meeting minutes and the ward meeting minutes.
- The hospital delivered training on duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety

incidents', and provide reasonable support to that person. Staff members were able to explain duty of candour. One member of staff gave an example of when it had been applied.

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

- The hospital monitored safety via a clinical quality dashboard and regular audit.
- Copies of the clinical dashboard were displayed in clinical areas and on staff notice boards. Information included number of incidents, number of complaints, clinical audit results, number of reported incidents, patient comments, feedback from complaints and NHS Choices feedback as well as the hospital's clinical performance indicators and readmission rates.
- Data supplied by the hospital showed that three patients had acquired a deep vein thrombosis (VTE) or pulmonary embolus following a surgical procedure between July 2015 and June 2016. Patients received a VTE assessment on admission. Assurance and monitoring of VTE assessment was undertaken via clinical audit. We reviewed the audit data for venous thromboembolism (VTE) compliance and saw the results were August 2015 (100%), November 2015 (100%), February 2016 (96%) and May 2016 (100%).
- Within all four patient records we reviewed there were completed risk assessments for falls and pressure ulcers and the appropriate venous thromboembolism assessment had been completed and any required action taken.

Cleanliness, infection control and hygiene

- The hospital infection prevention and control (IPC) rates were good for MRSA, MSSA (Methicillin-sensitive Staphylococcus aureus), Clostridium difficile (C. difficile) and E coli with no reported incidents between July 2015 and June 2016.
- Infection prevention and control meetings took place quarterly. Minutes reviewed from January and March 2016 demonstrated that policies and protocols such as the MRSA screening for patients and staff were reviewed and updated. The minutes also demonstrated that the IPC lead for the hospital liaised with a local NHS trust to ensure hospital protocols, such as MRSA screening and antibiotic prophylaxis guidelines were in line with national guidelines.
- The rate of infections during primary hip arthroplasty, primary knee arthroplasty, breast and gynaecological procedures was above the rate of other independent acute hospitals we hold this type of data for. The rate of infections during other orthopaedic and trauma procedures was similar to the rate of other independent acute hospitals we hold this type of data for. There were no surgical site infections resulting from spinal, upper gastro intestinal and colorectal, urological, cranial or vascular procedures.
- The hospital monitored and reported hospital acquired infections. There were 12 surgical site infections between July 2015 and June 2016. The hospital had investigated the surgical site infections reported. We reviewed four root cause analysis investigations and saw that they had been carried out in full and action plans attached. The hospital reported that they had consulted with a consultant microbiologist and had carried out a review of practices and processes in theatre and the out- patient department and identified no common link. Recommendations included temperature recording both intraoperatively and immediately post operatively, additional training and improved patient information on wound care. We reviewed audit data and saw that in February 2016, 71% of patient records reviewed showed that intraoperative temperatures had been recorded. In December 2016 this figure had improved to 100%.
- Three of the four operating theatres had laminar flow ventilation systems, which reduces the risk from airborne bacteria getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments, surgeon's and the patient's own skin. All surgical procedures requiring a surgical implant were carried out in these theatres. Other procedures carried out in theatres with laminar flow included orthopaedic surgery, urology, gynaecology, general surgery, vascular, ENT, dental and plastics.
- The fourth theatre was used for endoscopy procedures. It was also used for urology procedures such as flexible cystoscopies and other minor general anaesthetic day cases.
- There was a clear pathway for clean and contaminated flexible endoscopes. Used endoscopes were decontaminated in a separate utility room attached to

the theatre which meant that there was no cross contamination. Equipment was decontaminated in line with national guidance. Documentation records were in place that provided a full audit and traceability process.
- Custom designed trolleys were in place to transport endoscopes throughout the hospital, for example between theatres and clinic. The trolleys ensured clean (processed) and used (contaminated) endoscopes were kept separate and a colour coded cover on each tray (red / green) identified which were clean and which were used.
- A three-point decontamination wipe system was utilised for decontamination of the flexible fibre optic laryngoscope used in theatre for difficult intubations. A log book record was in place to record patient details and decontamination for full traceability.
- All areas of theatre were visibly clean. Cleaning schedules were in place and staff signed and completed records to demonstrate this had taken place. Records we reviewed demonstrated that the cleaning had taken place for November and December 2016 up to the date of our inspection.
- All areas within the surgical ward were visibly clean and tidy. We noted that the sluice in the dirty utility room was for domestic use only. The ward manager confirmed that a new sluice was being constructed and the existing sluice will be used for storage.
- Equipment on the ward was clean and a dated "I am clean" sticker was placed on equipment after cleaning to indicate it was ready for use.
- Staff wore uniforms with short sleeves and followed the bare below the elbows policy. Personal protective equipment (PPE), such as gloves and aprons, were available and we observed staff wearing appropriate PPE whilst administering patient care. We saw staff dispose of PPE appropriately.
- The hospital completed a quarterly hand washing audit. Results provided showed compliance between 88% in July 2015 and 91% in April 2016 against a target of 100%. For audit results that fell below 90% compliance the hospital policy required that an action plan be implemented to improve compliance. We saw that an action plan had been put in place. Action plans for audit compliance were shared at the ward and theatre stand up meetings.
- The hospital's sterile services were provided by an off-site central sterile services department for the decontamination of reusable medical devices. There was a tracking and traceability system in place for all surgical instrumentation equipment used.
- Sanitising hand gel dispensers were sited at the entrance to the hospital and at the entrance to theatres and to the ward. We saw hand gel dispensers in all three patient rooms that we visited.

Environment and equipment

- The ward consisted of 47 inpatient beds including three twin bedded rooms. All rooms had en-suite facilities. At the time of our inspection the hospital was having a new security system installed with a control pad access system.
- The endoscopy service had achieved Joint Advisory Group (JAG) accreditation in July 2013. Patients were admitted to the ambulatory unit, where there were three pre-operative bays. Separate male and female toilet facilities were provided in this area for patients following bowel preparation. Patients were escorted to theatre four, where the endoscopic procedure took place, and then recovered in the ambulatory 11-bedded area.
- Emergency resuscitation trolleys were available in theatre recovery and on the ward. The resuscitation trolleys were sealed with an identification tag which was recorded in the records. We checked the contents of the resuscitation trolley on the ward. The listed equipment was present and within expiry date.
- We reviewed records of the resuscitation trolley checks in recovery and saw that daily checks were completed and there were no gaps in records dating back to October 2016.
- The hospital used an external contractor to maintain and service equipment. All equipment checked across the hospital was within its service date and had an up to date electrical safety test. All were clearly labelled with the next date of service.
- We checked the difficult intubation trolley. A full check took place on a monthly basis and records demonstrated this had been completed. Difficult intubation guidelines were up to date and accessible for staff.
- The processing machines in use for endoscopy had been serviced and maintained. The machines were managed under an external service contract and staff

could demonstrate the process to report issues. Clear documentation of water testing, machine testing and servicing was maintained. There was no hard copy documentation of breakdown or repairs; however staff stated these were held electronically by the endoscopy lead nurse.

- There was a system in place to ensure that appropriate equipment was available for the operating lists and that back up surgical sets were available if a set was damaged or incomplete. Staff reported that the service worked well and surgical sets were always available for the complete operating lists.

Medicines

- Controlled drugs (CDs) were managed appropriately throughout both the ward and theatres. Controlled drugs were stored within double locked cupboards.
- We reviewed the controlled drugs in theatre one and on the ward. We found that daily morning and afternoon checks were completed. Medication checked was within expiry date and stock levels matched records.
- We reviewed the controlled drugs audit for June 2016 and saw that there was a 92% compliance with internal policy. Non-compliance related to the lack of storage facilities for patients' own controlled drugs or a separate area for controlled drugs for destruction. A larger cupboard had been acquired which provided more storage space.
- We reviewed the medicines audit for October 2016 which showed 79% compliance. The audit found that medicine fridges were untidy and cluttered, room temperatures were not recorded and there was no prescription pad recording process. We saw that an action plan had been put in place and that the changes had been implemented. The next audit was due in April 2017.
- All medication was stored appropriately in locked cupboards or fridges, in accordance with manufacturer guidance. Certain medicines need to be kept at recommended temperatures to maintain their efficacy. Records demonstrated daily checks for room and fridge temperatures where medications were stored. We saw that on two consecutive days fridge temperatures had been recorded that were outside the permitted range. The theatre manager explained that this had been escalated appropriately. The error had been in the recording of the temperature but the contents of the fridge had been destroyed as a precaution.
- Pharmacy support was provided by the local NHS trust.

Records

- The hospital used paper records. Staff used paper patient pathway documents to record the care provided. We reviewed four patient records during the inspection and staff were able to find the records requested quickly and without delay.
- We reviewed the complete patients' pathway from admission, through theatre and to discharge. Documentation was completed as required through the process. Pre-operative assessments, including physiotherapy assessment where appropriate, were complete and accurate in all records reviewed.
- Patient care plan from consultation, operating records and consultant reviews were included within the inpatient care record. We found that notes detailed who had completed each entry on the records for ease of traceability. However, we noted that in some instances the notes were not clearly legible.
- There were specific patient care pathways for each speciality, for example we reviewed two oncology patient records and saw that a specific chemotherapy patient pathway was used.
- We reviewed the medical records audits completed in January and April 2016. The result was 98% compliance for both audits. The audit looked at details of the patient records selected including patient details were entered correctly, referral letters were present, all recorded entries were dated, timed and signed by the care giver, entries were clear and legible, evidence of pre-admission assessment, and that the record provided a chronological account of the patient's care.
- Patient records were held securely in a locked room behind the nurse's stations. Nursing records were kept in the patient's room.

Safeguarding

- The hospital reported that there had been no safeguarding concerns raised between June 2015 and July 2016.
- Data provided by the hospital showed that 100% of theatre and ward staff were up to date with safeguarding level two training for both adults and children. The paediatric lead nurse and the matron were the nominated children's safeguarding leads and were trained in level three safeguarding.

- At the time of our inspection the hospital had temporarily suspended inpatient services for children and young people. The level of safeguarding training had been reviewed by the senior team and a decision had been taken to train all clinical staff in safeguarding level three. There was a focus on ensuring paediatric competencies were in place and staff were level three trained prior to recommencing the children's service.
- Staff had access to hospital safeguarding policies for both adults and children. We reviewed each policy and found them to be up to date and in line with national guidelines. The hospital policy had guidelines and flow charts with details of what to look for and how to report a concern.
- There was a safeguarding escalation process available in all areas. We saw safeguarding information on the staff notice board in theatre with details of how to raise a concern and where to access help and advice. A staff member confirmed that they knew how to escalate a safeguarding concern and where to get help and support should they require it.

Mandatory training (if this is the main core service report all information on the ward(s) here.

- Staff were aware of their responsibility to undertake and complete mandatory training. Mandatory training was delivered via an electronic system. The mandatory training programme included data protection, health and safety, emergency management and fire safety, infection control, workplace diversity, information security and clinical basic life support**.**
- Data provided by the hospital showed that mandatory training completion rate for staff in theatre was 99.5% and for staff on the ward was 90.3% against hospital target of 85%.
- Data supplied by the hospital showed that up to December 2016, 78% of theatre staff and 78% of ward staff were up to date with immediate life support training. This was below the hospital target of 85%. The resident medical officer (RMO) and matron, plus two members of the current recovery team had undergone advanced life support training (ALS). There was an action plan in place to train a further six staff members in ALS between March and July 2017.

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

- The hospital used the National Early Warning Scores (NEWS). NEWS is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient observations. We reviewed four sets of patient records and saw that the NEWS score had been completed appropriately.
- There was no specific triage or escalation process for a deteriorating patient following chemotherapy. We brought this to the attention of the senior team. Following inspection the hospital told us that they were introducing the United Kingdom Oncology Nursing Society (UKONS) Oncology/Haematology 24 Triage Rapid Assessment and Access Toolkit. Staff who required training had been identified and training of all staff would be completed within three months.
- The hospital used the World Health Organisation (WHO) five steps to safer surgery checklist. The five steps to safer surgery incorporates a briefing before surgery commences at the beginning of the list and debrief at the end. We observed two cases in theatre and saw that the WHO checklist was carried out appropriately in both cases.
- We reviewed four patient records and we found correctly completed checklists in all four records. Audit data provided by the hospital showed 100% compliance with five steps to safer surgery in February and May 2016. This audit was a quantitative audit and did not address the quality of the check. We were not made aware of any observational audits.
- A pre-assessment staff nurse told us that patients had a pre-operative assessment before the planned procedure. We saw that the hospital used the National Institute for Health and Care Excellence (NICE) guidelines NG45 (April 2016) routine preoperative tests for elective surgery. Any concerns were escalated to the surgeon before the patient's admission.
- There was a service level agreement in place with the local NHS Trust for the transfer of a patient who became critically ill. The hospital had a policy for the transfer of a critically ill patient which contained checklists to ensure that the process was followed correctly. Staff were aware of the process to escalate a deteriorating patient and to facilitate a patient transfer.
- All heads of department (HoDs) were responsible for risk assessments within their own areas. There was a standard operating procedure in place for escalation of departmental risks to the hospital risk register.

Good

Surgery

- The hospital followed up patients 24 hours after discharge by telephone. The ward provided all patients with a contact number for the hospital prior to discharge should they have any concerns.

Nursing and support staffing

- The hospital used bank and agency staff to cover vacancies and sickness. During the reporting period July 2015 to June 2016 the use of bank and agency staff ranged from 11% to 2% based on monthly data provided by the hospital. The use of bank and agency staff was lower than average when compared to other independent hospitals we hold data for.
- Staffing numbers were planned in advance, taking into account the number of patients admitted on each particular day and the type of surgery they were having. The hospital had an acuity tool in place but the ward manager told us that they didn't tend to use it as they knew the ward and knew what staff were needed. There were no reported staffing shortfalls on the ward.
- The theatre list was viewed in advance by the senior theatre staff. Staffing was then provided to ensure that the correct skill mix was available for the type of surgery performed.
- Staff we spoke with in theatre recovery told us that they felt that recovery was short staffed on occasions and that at times delays were caused by ward staff not collecting patients from recovery. We raised this with the theatre manager and matron who said that staffing was flexible and additional staff could be reallocated to support recovery and operating lists slowed if necessary. We reviewed the staff rota in recovery between October and December 2016 and saw that staffing levels were sufficient for the planned surgery lists. However, there was no formal monitoring undertaken locally to record any delays in recovery or assess if there was an impact on theatre list utilisation.

Medical staffing

- The hospital had 140 consultants working under practising privileges. Surgery was consultant led. All consultants remained responsible for their patient for the duration of their stay and were on call until their patient was discharged. Consultants were required to remain within 30 minutes travel time of the hospital. Nursing staff told us that consultants were very responsive and could always be contacted when required. Buddy systems were in place to cover annual leave and other leave. In such cases the hospital was advised who was responsible for patient care whilst the surgeon was unavailable. There was a process in place to ensure emergency anaesthetic review was available.
- The hospital had a contract with an agency to supply resident medical officers (RMO). The RMOs were on call 24 hours a day. They worked seven days followed by seven rest days. RMOs were supplied by an external company who also provided relief RMOs if a rest period was required. The company checked daily to monitor the number of calls the RMO had received. The matron also met with the RMO daily to ascertain their workload and the impact of any excessive night time working. This ensured the RMO was able to fulfil their role safely.

Emergency awareness and training

- The hospital reported that they had regular fire evacuation tests and evacuation plans in place.
- We reviewed the Ramsay Health Care UK Business continuity management policy. This was dated August 2010 and was reviewed every three years. At the time of inspection this policy was past its review date of August 2016 by four months. Within this policy it was outlined that continuity plans should be created for the possible occurrence of a variety of exceptional operating and environmental conditions.
- The hospital had a backup generator for use if major power failure was to occur and green business continuity management folders were in place to provide staff with policies and guidance in the event of an emergency.

Are surgery services effective?

Good

Evidence-based care and treatment

- The hospital policies and procedures were developed nationally by the Ramsay group and took account of relevant best practice guidance including that issued by the National Institute for Health and Care Excellence (NICE) and relevant royal colleges such as the Royal College of Nursing (RCN). For example NICE NG51 Sepsis: recognition diagnosis and early management.
- The Ramsay group provided regular updates on NICE guidance. Updates were circulated through each

hospital and discussed at clinical governance meetings (CGM). We reviewed four sets of CGM minutes and saw that national guidance and new legislation was a standing agenda item.

- Hospital policies were available on the hospital intranet. Paper copies of policies were also held in files accessible to staff. As policies were updated staff were advised and were required to read the policy update and sign to confirm that they had read it. We saw a sample of the folders and completed staff sign off sheets.
- We reviewed a selection of hospital policies, for example, the consent to treatment for competent adults and young people policy and the infection prevention and control policy. The majority of policies we reviewed were in date; with a review date identified and referenced best practice and guidelines.
- We saw that the endoscopy operational policy was out of date and had been due for renewal in August 2016. We were told that the service was waiting for updates from the Joint Advisory Group (JAG), however there was no covering statement attached to inform staff of this and no indication as to when this would be followed up and the policy reviewed.
- In theatre four there was a folder containing out of date policies and risk assessments, relating to endoscopy. We brought this to the attention of the theatre manager and general manager. We were told that it was the endoscopy lead's own resource file. However, this folder was accessible to staff and could be used to access out of date policies and processes. The folder was immediately removed.
- The hospital had Joint Advisory Group (JAG) accreditation for endoscopy services which had been reaccredited in December 2015. This meant that the service had been assessed against a set of criteria and had demonstrated that it provided care and treatment in line with relevant national best practice guidance such as that issued by the Royal College of Physicians.
- Implant registers were in use in theatre to record all surgical implants; records included serial numbers, expiry dates of implants and patient details to allow traceability. Completed implant registers were archived in the theatre manager's office. The hospital participated with the National Joint Registry for hip and knee surgery. However, the hospital was waiting for logins to enable recording of implants on the breast and cosmetic implant registry.
- The hospital were aware of the Royal College of Surgeons guidelines for cosmetic surgery. We reviewed the hospital consent policy and saw that consent for cosmetic surgery required a two way consent process with a two week cooling off period to allow the patient to reflect on the decision as required in the guidelines.
- There was no specific paediatric policy in place prior to the recent review of the service. This had been rectified and a draft policy was seen for the delivery of children's services dated December 2016 and this was finalised in January 2017 ahead of the service recommencing.
- Oncology patient records held on site did not contain clearly defined drug protocols. The chemotherapy protocols in use at Oaks Hospital were based on the protocols used at the local NHS trust and had not been reviewed for six years. We raised concerns during inspection and the senior team took action in response. An initial action plan was devised which included contacting other hospitals within the Ramsay Health Care group and the local NHS trust for updated protocols. However, it was found that other hospitals within the group were using the same and the NHS trust was moving to a new electronic prescribing system. In response the hospital identified the action to review and redraft paper based protocols and submit to the clinical governance committee (CGC), individual oncologists and Ramsay UK pharmacy governance group in draft format in January 2017 with the aim to finalise at the February 2017 CGC meeting.

Pain relief

- Pain assessment tools were embedded in the National Early Warning Score (NEWS) chart. In all four of the patients' notes we reviewed we saw that staff had carried out regular pain assessments and the patient had received pain relief as prescribed by the consultant.
- We spoke with three patients about their pain relief. All said that the staff had checked their pain levels regularly and they had received appropriate pain relief as required.
- In recovery we observed the recovery nurse assessing a patient's pain at regular intervals as the patient was recovering from anaesthetic.

Nutrition and hydration

- The hospital reported that nutrition and hydration was assessed on admission with any special dietary needs

communicated to catering staff by the ward staff. There was access to a trained dietician to provide additional support and individualised assessment for patients with specialist dietary needs.

- We spoke with three patients regarding food. One stated, "Food is lovely and there is a wide choice". Another patient reported that they had complained that the food was too salty on a previous admission and that this time the salt level in their food had been reduced for which they were very impressed.
- Patients were provided with information regarding fasting prior to procedures in the outpatient setting. We spoke with one patient after they had received a surgical procedure who reported that they had received both written and verbal instructions regarding fasting prior to attendance for surgery.
- We reviewed the nutrition and hydration audits undertaken by the hospital and found a low rate of compliance. The results for December 2015 were 46%, March 2016, 69% and June 2016, 56%. Issues included low completion rate of fluid balance charts, starvation times not recorded, fluid input and output not always recorded correctly and running totals and positive/ negative balances not recorded or escalated. We raised this with the ward sister who confirmed that an action plan had been implemented to improve compliance. The most recent audit in December 2016 showed an improvement to 90% compliance. In addition, a new fluid chart was being rolled out and an e-learning module was being developed to improve compliance further.
- The hospital did not monitor or audit patient fasting times. This meant that the hospital were not able to assess whether patients were fasted for an extended period whilst waiting for surgery.

Patient outcomes

- The hospital collected Patient Reported Outcome Measure (PROMs) data for total knee and hip replacements using the Oxford Hip and Knee score. Results were compared against Average Expected Health Gain and compared to all hospitals in the country, both independent and NHS. All results for this hospital were within range of the England average for NHS patients.
- The hospital had seven cases of unplanned transfers of a patient to another hospital during the reporting period July 2015 to June 2016. This equated to 0.4% of admissions. This was not high when compared to other independent health care providers that we hold information for.
- The hospital had 12 cases of unplanned readmissions during the reporting period. This equated to 0.2% of admissions. There were five cases of unplanned returns to theatre during the reporting period. This figure was not high when compared to other independent health care providers that we hold information for.
- Regular audits were carried out by the hospital to monitor and improve patient safety, experience and outcomes. We saw evidence of local auditing in relation to records, medicines management and infection control and noted that action plans and the subsequent monitoring of those plans for improvement was undertaken. This was overseen by the clinical governance committee.

Competent staff

- There was a monitored process in place for consultants working under practising privileges via the medical advisory committee (MAC) and the general manager (GM). Ongoing scope of practice and appraisal were monitored. However, there was a discrepancy between the electronic Ramsay system and the local paper record system. For example scope of practice and self-declaration forms had been completed locally but these could not be uploaded onto the electronic system which meant that neither system easily tracked the up to date status of consultants' compliance with practising privileges.
- Data reviewed on inspection demonstrated that not all consultants had an up to date appraisal. We were informed that the hospital allowed a grace period for appraisals however this was not identified within the Ramsay facility rules. We raised this with the general manager and immediate action was taken. The grace period was removed and letters of communication sent to consultants.
- There was one specialist-trained nurse for oncology within the hospital. This was sufficient for the small number of patients seen. This nurse was on duty when any patients were seen and treated. They had completed regular competency training and updates, working alongside colleagues at another Ramsay

hospital site where oncology has a larger service. Documentation was seen of competencies for 2015 and 2016. They were due to renew these competencies in January 2017.

- There was a monitoring process in place in theatres to ensure all surgical assistants attending had the correct competence. Advanced scrub practitioners, who assisted a consultant during surgery, were required to provide a copy of their indemnity insurance, their Nursing and Midwifery Council (NMC) / General Medical Council (GMC) registration and their hepatitis B status before working at the hospital. We saw a copy of the folder holding this information.
- Staff appraisals were carried out on a rolling year basis. Data provided by the hospital showed that 100% of nurses and 89% of operating department practitioners and healthcare assistants within the theatre department had received an appraisal. For the same period within inpatient ward areas, 67% of nurses and 67% of healthcare assistants had received an appraisal. We discussed this with the ward manager who stated that the remaining 33% were staff either on maternity leave or long term sickness.
- There was an established induction programme for new staff, including agency staff. Agency staff were required to be signed off as competent by a senior team member.
- The hospital reported that there were a number of training opportunities for staff, including on site and external training programmes as well as personal development plans to encourage development opportunities. The Ramsay group also offered leadership training for heads of department and team leaders to support career progression.

Multidisciplinary working

- The hospital had a service level agreement (SLA) in place with the local NHS trust for the transfer of patients. The local NHS hospital was geographically near to Oaks Hospital and staff reported good communication with the local trust.
- A long-term agreement with the local NHS Trust is in place that enables patients diagnosed with a cancer to be discussed at the relevant speciality multi-disciplinary team (MDT). Once patient diagnosis is confirmed the responsible oncologist takes the case to the multidisciplinary team (MDT) meeting at the local NHS trust. The MDT will discuss the case and the diagnostic findings and prepare the treatment plan for the individual patient.
- Staff stated that teams, both nursing and medical, worked well together. Nursing handovers took place at the start of each nursing shift. Staff we spoke with stated that communication between consultants and nursing staff was effective and consultants could be contacted when needed.
- Staff reported that physiotherapy and diagnostic imaging was easily accessible to the patients and the staff in these areas worked closely with their colleagues on the ward.

Seven-day services

- Resident medical officers (RMO) were on call 24 hours a day, seven days a week to provide an immediate review of patients should it be required, or to provide emergency treatment. We spoke with a RMO who told us that they could contact consultants if they had a concern about their patient.
- An out of hours on-call service was provided by both diagnostic imaging and theatres.
- The service had on site physiotherapists who provided care to inpatients seven days a week.
- Pharmacy services were provided by the local NHS hospital via a service level agreement (SLA). The service was available for advice and emergency drugs 24 hours a day.
- There was a system in place to ensure that chemotherapy drugs were prescribed, delivered and available. Chemotherapy was usually administered to patients on a Thursday. The patient was seen on a Tuesday for pre-treatment blood tests, once the results were received the consultant would fax the prescription and bloods results to the pharmacy, drugs would then arrive and be checked in at the Oaks on the Wednesday evening.

Access to information

- Staff had access to both electronic and paper based policies. During our inspection we requested a staff member demonstrate how these policies could be accessed. The member of staff easily located a specific policy we requested.

- Nursing and medical documentation was easily accessible. Staff told us that when information was needed it was readily available. Test results and diagnostic imaging were held electronically. The consultants and RMO had access to these as required.
- There was an established process for getting notes via the bookings team ahead of surgery.
- Patients were provided with a discharge information form with appropriate information about after care and follow up as well as contact details for any concerns. A copy of the patient's discharge summary was provided to the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had policies in place relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had access to these policies via the hospital intranet. It was important that staff have an understanding of when they may need to consider a person's capacity in order to support them in making decisions about their care and treatment options. Staff we spoke with had an understanding of both MCA and Deprivation of Liberty Safeguards.
- We saw a mental capacity assessment form that had been completed for a patient living with dementia. The form had been completed by the consultant and the matron. The patient was deemed to have capacity and completed their consent for treatment. This was in line with the requirements of the Mental Capacity Act 2005.
- The hospital participated in consent audits looking at the completion of documentation surrounding consent. The audit was based on relevant guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). Overall compliance was as follows: March 2016 (96%), June 2016 (95%), September 2016 (99%) and December 2016 (99%).
- We reviewed four patient records and consent forms were completed appropriately and signed by the patient and consultant.
- In one set of notes we saw that the confirmation checklist on the day of surgery had been completed by a healthcare assistant. Part of this checklist was to confirm that the patient was still consenting to the surgery. The hospital consent policy states that the checklist confirmation of consent should be taken by a member of staff who was registered with a professional body, for example, the nursing and midwifery council. We brought this to the attention of matron who confirmed they would address the situation with the ward accordingly.
- We also observed in the notes we reviewed patients had consented for physiotherapy and also for data to be recorded on the National Joint Registry.
- We reviewed two sets of notes for patients receiving oncology treatment. Neither record contained a copy of the consent form, which we were informed was held within the consultants' own notes. In one set of notes the box indicating the patient had consented for treatment was not checked. We raised this with the senior staff who took immediate action. Following inspection the hospital told us that these patient records were awaiting the consent form which had been requested from the consultant archive as an urgent request. All future new patients would have their consent forms and clinical records copied to ensure they contained their health records and were complete and up to date.

Are surgery services caring?

Good

Compassionate care

- We reviewed the hospital Friends and Family Test (FFT) results between May 2016 and August 2016. The results showed that in May 100% of patients who responded would recommend the hospital to friends and family. In June this figure was 96%, in July 93% and August 100%. However the response rates were low; May 21.9%, June 7.3% July 6.6% and August 5.2%
- The hospital carried out a patient survey, the results from October 2016 showed that 95.1% of patients who responded were likely to recommend the hospital and that 98% said that they were given privacy to discuss concerns.
- We observed patients being treated with dignity and respect. Patients were covered at all times whilst being prepared for surgery. Where patients were receiving treatment on the ward, staff would check before entering a patient's room and doors were closed when care was being given.

Good

Surgery

- We saw evidence that the patient's confidentiality was protected. Doors were closed during consultations so conversations could not be overheard by other patients or visitors.
- We saw that staff were kind and considerate in their interactions with patients.
- One patient told us that they were "really impressed" with the care they have received. Another patient said that the "staff were excellent and nothing was too much trouble".

Understanding and involvement of patients and those close to them

- Three patients we spoke with told us that they had been fully informed about the procedure that they were having. One patient said that everything had been explained very clearly and they were given the opportunity to ask questions.
- Another patient told us that their daughter was looking after them when they were discharged and the nurses had taken the time to explain the care to their daughter.
- 97.1% of patients who responded to the patient survey in October 2016 said they felt involved in the decisions about their care and treatment.

Emotional support

- One patient told us that they had been very anxious before their surgery and that the nurse looking after them had been supportive and answered all their questions to put them at ease.
- We saw recovery staff being supportive and reassuring to a patient, coming round from anaesthetic, who was very confused.
- A counsellor was available to offer psychological support by appointment.

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital offered services for both NHS and private patients. There were several routes for patients to access the service, either via self – referral directly, referral from their GP to a consultant at the hospital or via NHS contract.
- There was awareness from the general manager and the senior team that the hospital utilisation and capacity could be improved to both increase the hospital performance and support the overall health system by continuing to negotiate and potentially increase the number of NHS contracts for the benefit of patients. The senior team recognised that there could be improved streamlining of day care patients and discharge processes.
- We reviewed theatre utilisation between October and December 2016. Theatre schedule utilisation ranged between 23% and 70% in October, 2% and 68.5% in November and 33% and 63% in December. Working day utilisation ranged between 2% and 39% across the three months, to varying degrees for each theatre. Utilisation was undertaken corporately and figures sent each month by way of a theatre timing pack, which, as well as detailing weekly and monthly utilisation, identified utilisation by specific consultant and service speciality. However, there was no evidence that this information was being actively used by the theatre manager to identify and take action to target the areas for improvement to improve utilisation.
- All surgical procedures were planned and patients were offered flexibility and choice when arranging admission dates for surgery. There was an established process for patient booking.
- Prior to the temporary suspension of paediatric services the hospital saw approximately 90 children for surgery per year, the majority being ear, nose and throat (ENT) with a smaller number of urology. Following a review of the paediatric service the hospital found that there were concerns so they took the decision to suspend the service temporarily to finalise the resolution of security issues, staff training and competencies, the operational plan and the consultant scope of practice. Services were due to resume in February 2017. Security had been updated with key card access to the ward and theatre, safeguarding training updates and a review of policies and procedures.
- The hospital offered treatment to a small number of oncology patients. Data provided from the hospital in December 2016, ahead of the inspection, demonstrated that there had only been two oncology patients treated

at the hospital. Both of these patients had found it more convenient to be treated nearer their home rather than having to travel to the oncology centre at another Ramsay hospital site.

Access and flow

- The hospital liaised with the local NHS trust when booking NHS patient appointments. The bookings coordinator contacted patients directly to book them in for surgery. Date of referral, date of scheduling and breach dates were recorded and monitored. More than 90% of NHS patients were admitted for treatment within 18 weeks of referral in April 2016 to June 2016. Figures in April 2016 showed that 95.6% of patients were admitted within 18 weeks of referral. In May 2016 the figure was 96.5% and in June 2016 it was 96.7%.
- Times for surgery were monitored by the inpatient booking team. The team worked closely with the consultants to prevent the breach of patients and identified the reason why a breach had occurred and provided additional theatre space if possible.
- Surgical procedures were booked in advance and the service did not expect emergency patients for surgery. This meant that the hospital could plan staffing levels and resources to meet the requirements of the number of patients.
- In some instances patients needed to return to theatre because of unexpected complications. The theatre manager told us that the department operated an on-call system to provide a core theatre team when required out of hours.
- All admissions were agreed with the admitting consultant. Patients received a nurse led pre-assessment before admission. The hospital had inclusion and exclusion criteria and screening of patients took place at an out-patients pre-assessment appointment prior to admission.
- The hospital reported six cancelled procedures for a non-clinical reason between July 2015 to June 2016. This was low when compared to other independent health providers that we hold this information for. All six were offered another appointment within 28 days of the cancelled appointment.

Meeting people's individual needs

- The hospital had access to a translation service for patients whose first language was not English. This could be booked in advance of the patient's attendance at the hospital. A telephone translation service was available if a translator was required at short notice.
- The theatre department had access to equipment specifically for bariatric patients. The ward arranged for appropriate beds for bariatric patients who required a wider width or additional mattress support for their weight. This was arranged through the pre-admission and pre-assessment process.
- All the hospital facilities were accessible for wheelchair users.
- The hospital was piloting a patient information diary which allowed patients to record key information, questions or concerns as well as having information on all aspects of the patient's journey from pre-operative assessment to discharge advice. The implementation of this diary was as a result of the patient satisfaction survey particularly relating to communication and discharge advice. The patient information diary enabled patients to feel more informed and allowed more involvement in decisions around their care.
- The hospital had provision for carers and relatives to stay with patients for support if required. The flexible visiting hours allowed patients to have contact with those close to them when needed.

Learning from complaints and concerns

- Between July 2015 and June 2016, the hospital received 43 complaints. The rate of complaints was lower when compared to other independent hospitals that we hold data for. This data pertained to the hospital as a whole.
- All complaints were investigated in line with the Ramsay Health Care UK Operations Limited policy. The hospital resolved the patient's concerns in the majority of instances. No complaints have been referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS) in the same reporting period.
- The outcomes of complaints were discussed at monthly heads of department (HoDs) meetings so that information and learning could be shared with staff on a departmental basis. The progress of complaints was discussed at the weekly senior management team meeting. We saw minutes from this meeting and saw that complaints were a standing agenda item. All complaints were overseen by the general manager.

Good

Surgery

- The hospital received a weekly summary of patient feedback via a 'hot alert' spreadsheet which was sent to all heads of departments via the general manager for action. This was monitored via the head of departments committee to assess any action that needed to be taken and to identify if any trends had developed following patient feedback. 'Hot alert' information was also included in the clinical dashboard available to all staff

Are surgery services well-led?

Good

Leadership / culture of service related to this core service

- The hospital was led by the general manager supported by a senior management team (SMT) consisting of matron, operations manager and regional finance manager. Under the clinical management of matron were the quality and improvement lead and individual heads of department (HoDs), including the ward and theatre manager.
- The general manager expressed that they felt supported by the Ramsay Health Care UK executive team. They felt empowered to raise concerns, stated they felt listened to whilst there remained a healthy level of challenge.
- The ward manager and theatre manager both told us that they were proud of their staff and the commitment and dedication they demonstrated to their patients and the hospital.
- We spoke with two members of staff in the theatre department who reported that they felt that morale was not good. The general manager was aware of these concerns and staffing morale in theatres was on the risk register. The senior management team reported that they were working with the theatre team to improve culture and morale.
- Staff we spoke with were very positive about the general manager. They said that they were visible and easily approachable and felt that they listened to staff concerns. Since the general manager had been in post, the offices of the matron and the general manager had been relocated to the front of the hospital to improve accessibility and visibility to staff.
- The medical advisory committee chairman was very positive about the input of the general manager and regional manager and told us that there had been positive changes, such as the review of children's services that had been well received by the consultants.

Vision and strategy for this this core service

- The hospital vision is to be the elective health care provider of choice. This was underpinned with a strategy of providing compassionate, courteous, competent and conscientious health care, ensuring quality patient outcomes, providing ease of access to elective healthcare and continuously improving via feedback, auditing, analysis and review.
- Individual pocket guides were available to staff outlining fundamental standards of care for staff including culture and the "Ramsay way". There are six core values that are based on staff and the service they provide being the organisations most valuable asset.
- There was a premium service for private patients identified through a separate waiting area and a premium menu.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The hospital governance issues were managed and discussed through various meetings including the medical advisory committee (MAC) meeting, heads of department (HOD) meeting, senior management team (SMT) meetings and the clinical governance committee.
- The medical advisory committee (MAC) met every three months. Reports from the clinical governance meeting and senior management team meeting were reviewed by the MAC. We reviewed the minutes of meetings held in March and June 2016. The minutes were comprehensive in detailing discussions of the meeting agenda items.
- There was a clinical governance committee (CGC) which met quarterly. We reviewed minutes from meetings in February 2016 and May 2016. We saw that there were discussions around core topics such as incidents, infection prevention and control, and complaints.
- The general manager had put into action a focus on risk management. The heads of department had undertaken risk assessment training in October 2016 to

assist them in identifying risks. The general manager had monthly meetings with the heads of department to support them to have ownership with identifying, monitoring and reducing risk in their areas.

- The hospital had a standard operating procedure for escalation of active risks onto the hospital risk register. We reviewed the policy which outlined what constituted a risk and contained a flowchart outlining the risk management process.
- The ward and theatre managers both confirmed they had access to the hospital risk register and were aware of the risks in surgery. For example, the low morale amongst theatre staff was identified on the register and the senior team were working with staff to attempt to address this.
- Staff confirmed that information relating to quality, risk and governance were shared in team meetings. Minutes from the theatre stand up meetings confirmed this.
- Quality improvement was assessed through a process of local audit. The hospital undertook regular audits in relation to basic care and practice. We saw that action plans had been put in place to improve performance in areas where compliance was low. For example, the nutrition and hydration audit had low outcomes for four consecutive audits despite an action plan being put in place. We saw that the hospital had taken further action, implementing further training and implemented a new nutrition and hydration recording form and fluid chart. The two most recent audits had showed an improvement in compliance to 90%.
- The senior team had identified areas of improvement for the children's service which had prompted the temporary suspension until security measures, policies and training had been put in place. However, concerns raised on site regarding the oncology service identified the need for increased oversight and a regular effective review of those services that had low patient numbers to ensure patient safety and staff competency was maintained. As stated, the senior team responded appropriately on site to address concerns raised.
- There was an established corporate and local process for new procedures. The consultant was required to provide information for the justification of any new procedure including the establishment of a research base. The proposal was then reviewed to ensure it would be within the normal scope of practice for the consultant and due diligence given to the procurement needs of additional equipment and training requirements to ensure staff competence. This then was presented to the MAC for review and to the medical director and clinical director for Ramsay Health Care. It would also be considered at both the infection prevention and control meeting and CGC. An example provided was the potential use of a different orthopaedic prosthesis.

Public and staff engagement (local and service level if this is the main core service)

- The hospital had a number of processes in place to gain feedback from patients such as the Friends and Family Test, 'hot alerts', patient survey and through the monitoring of compliments and complaints.
- The hospital reported that they are in the early stages of developing a patient user group to encourage feedback from patients and to allow patients to be involved in improvements.
- The hospital carried out an annual staff survey to gain feedback from staff. The results from the survey of February 2016 showed high positive results for communication and collaboration (84%) and customer focus (90%) and lower results for direct line management and pay, benefits and recognition (70%).
- The hospital had mechanisms of staff engagement including information boards, team meetings and the general manager's newsletter.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The hospital apprentice programme won a newcomer award at the National Apprenticeship Awards November 2015.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- There had been no never events or serious incidents within outpatient and diagnostic imaging services between July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital reported 71 clinical, and 16 non-clinical incidents within outpatient and diagnostic imaging services between July 2015 and June 2016. The assessed rate of clinical incidents is similar to the rate of other independent acute providers. The assessed rate of non-clinical incidents was below the rate of other independent acute providers.
- Staff followed an incident reporting policy. This was up to date and outlined how to report incidents on the hospital's electronic reporting system. Senior staff stated that this was a transparent system and all staff had access. They gave an example of accessing lessons learnt and outcomes of a particular incident. Staff we spoke to were able to demonstrate this process and felt confident that reported incidents would be investigated.
- A senior nurse talked us through a root cause analysis (RCA) for an incident regarding missing histology samples in transit. There was evidence of a full investigation, lessons learnt and shared. Improvements were made by changing the method of transport and introducing a sample log book.
- Staff we spoke to told us they were updated with the outcomes of these incidents, in person, via departmental meetings or the department newsletter. We confirmed this by reviewing meeting minutes, containing evidence of investigations and lessons learnt.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (2000) (IR(ME)R). Diagnostic imaging services had procedures to report incidents on the electronic system and to a radiation protection advisor (RPA). There had been two reportable IR(ME)R incidents, concerning duplicate images being taken, between January 2015 and December 2016.
- We reviewed the RPA responses to these incidents and confirmed they had been investigated. Improvements had been made in the department following the RPA's advice, such as x-ray cassettes being deleted and cleared when not in use, and additional checks being made with the patient.
- Since 1 April 2015, all independent healthcare providers are required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. All outpatients and diagnostic imaging staff we spoke to understood the principles of duty of

candour. They explained the importance of apologising, when mistakes were made, whilst being open and honest. We saw an example of this taking place following a patient's complaint.

Cleanliness, infection control, and hygiene

- All areas we inspected throughout outpatients and diagnostic imaging were visibly clean. Cleaning schedules in clinical areas were completed daily and up to date. We witnessed signed and dated green stickers stating 'I am clean' being adhered to equipment and room doors to indicate the area had been cleaned.
- The outpatients department had a suitably stored stock of cleaning and sanitising equipment. We noted housekeeping staff cleaning and checking toilets regularly. Cleaning schedules for these rooms were also fully documented and up to date.
- Clinical waste and sharps bins were used appropriately for the safe disposal of waste. All were visibly clean and sharps bins were correctly assembled, within safe fill limits, signed and dated.
- We reviewed the infection prevention and control policy, which referenced national guidance. We found that staff adhered to this policy and had good knowledge of infection control techniques. We spoke to two members of staff who explained the training they had received in relation to infection control.
- All staff wore uniform and adhered to the 'bare below the elbow' policy. This enabled staff to efficiently wash their hands and prevent spread of infection.
- Hand sanitizer was available at the entrance of each department and on the reception desks. Each consultation room had portable hand sanitizer on the desks and a sink for handwashing. We witnessed staff using these and washing their hands in between each patient. This was in line with National Institute for Health and Care Excellence (NICE) QS61 guidance.
- Personal protective equipment (PPE), such as gloves and aprons were readily available in the clinical areas. We witnessed these being used, and all available stock was within its expiry date.
- The hospital had no incidents of MRSA, Escherichia coli or Clostridium difficile in the reporting period July 2015 to June 2016.
- Infection prevention control formed part of staff's mandatory training and the hospital had a designated infection prevention lead nurse, whose role was to work with departmental links to ensure a safe, clean environment for patients. Data provided by the hospital post inspection demonstrated that 100% of outpatient and diagnostic imaging staff had completed infection control training. One member of senior outpatient staff confirmed this took place. There were clear infection control measures in place to reduce the risk of infection. For example staff cleaned couches and laid fresh paper sheeting between patients.
- Reusable medical devices were sent to a local central sterile services department (CSSD) for cleaning, decontamination and sterilisation. There was full tracking and traceability of equipment leaving and returning the hospital. A service level agreement (SLA) was in place to support this arrangement.
- The infection prevention lead nurse conducted random infection prevention control audits. Information submitted by the hospital showed staff compliance with hand hygiene infection prevention control was 100% for the outpatients and radiology department in their most recent, quarterly audit, dated May 2016. We reviewed the infection prevention control meeting minutes from January 2016 and April 2016, confirming audit results were on the set agenda.

Environment and equipment

- The outpatients department consisted of 14 consultation rooms. Each room was carpeted, and had a separate clinical examination room attached, with hard flooring. These, along with the corridor areas, were bright, well-lit and visibly clean. The hospital had clear signage to all departments.
- Diagnostic imagining consisted of two x-ray rooms and an ultrasound room. There was a mobile unit on the premises for magnetic resonance imaging (MRI) and computed tomography (CT) scanning, provided by an external company. We confirmed there was easy and safe access to this unit.
- Waiting rooms were spacious, carpeted and had adequate and appropriate seating, for example various seat heights and smaller chairs for children. One patient commented that their initial impression was very good. There was a premier care lounge for privately funded patients.
- Both outpatients and radiology had their own reception areas, with good oversight of the main patient waiting

areas. This kept people safe and ensured only patients and authorised personnel could enter this area. We noted that patients were escorted by staff when moving around the department.

- Rooms and corridors were free from clutter, except the department's clean utility room. This had equipment behind the door and in the middle of the room. This presented a trip hazard, which was moved out of the way, after we indicated this hazard, during our inspection.
- Staff told us they had sufficient equipment to meet the needs of their patients.
- The outpatient and radiology department shared their own trolley with resuscitation equipment on. We noted that this was securely tagged to ensure contents were kept safe and opening of the trolley could be audited. Records from December 2016 showed that this tag and equipment on top of the trolley was checked every working day. Staff checked the contents of the resuscitation trolley, including drugs, weekly and replaced the tag. This ensured the trolley was complete and safe to use.
- All resuscitation electrical equipment also had up to date safety testing. We checked all sterile equipment on the resuscitation trolley and found some items, such as nasopharyngeal airways and intubation blades, in open packets which compromised their sterility. Staff stated that this was for ease of access. We raised this with senior staff, who took action and removed and replaced the items. We checked the trolley later in the day, and on our unannounced inspection, and found all equipment to be sealed.
- The department also had a paediatric resuscitation grab bag, adjacent to the trolley. This was also tagged, and we saw evidence that this was checked weekly. All equipment was present, in date and sealed.
- We checked 20 pieces of single use equipment from store cupboards throughout outpatients and diagnostic imaging. All were within their expiry date and sealed, except one lubricant gel sachet. On further inspection we checked 10 sachets, and six were out of date. We raised this with the nurse on duty, who addressed the issue immediately.
- Waste was managed in line with national guidance. Clinical waste was segregated from domestic waste and sharps were disposed of in plastic sharps bins.
- An external company serviced outpatient equipment. All equipment we checked was labelled, and within their service dates.
- Imaging equipment was also tested and serviced through an external company. Up to date maintenance records were kept. These included handover sheets from the engineer, including details of work complete, any issues found and signatures to confirm equipment was safe to use. Risk assessments, such as that for over exposure, had also been carried out for the use of radiation within the department environment.
- Lead aprons were used for patients to reduce their exposure to radiation. These were visibly clean and in good working order. We confirmed that they were visibly checked daily for damage and screened yearly for internal damage to the lead.
- The radiology department used a mobile medical imaging device, called a C-arm, which was moved across different areas of the hospital. We reviewed the risk assessments for this transfer and the equipment maintenance records, both were in date.

Medicines

- Pharmacy services were provided by the local general hospital via a service level agreement (SLA). We reviewed the SLA document and noted that it was in date. We confirmed this service was available for advice and emergency medicines 24 hours a day. Staff spoke highly of this service and recalled an occasion when they sought advice out of hours following a refrigeration breakdown. We confirmed appropriate action was taken following this advice, and the appropriate medication was destroyed and replaced.
- Controlled drugs were stored in line with The Nursing & Midwifery Council (NMC) Standards for Medicine Management. These were locked in a double drug cupboard within the clean utility room and the keys were carried by the department managers. The hospital matron was the named controlled drugs accountable officer (CDAO) for the hospital.
- All controlled and non-controlled drugs were within their expiry dates. We reviewed the checking history of controlled drugs for October, November and December 2016, which showed that these were checked daily when the department was open and that all drugs were accounted for.
- Medication was stored according to manufacturer's instructions, either in a refrigerator or at room

temperature. We checked records and confirmed that these temperatures were within range. Records from 25 February 2016 to 20 December 2016 confirmed this was checked every working day.

- The hospital used guidance from the Department of Health and NMC Standards for Medicine Management to complete controlled drug audits. These were completed every three months. We reviewed the most recent audit submitted, dated June 2016 and noted that the hospital scored 92%. The hospital's target was 100%. The hospital policy required action plans to be implemented if audit results fell below 90%.

Records

- The outpatients service had a system for preparing the patients' notes a week prior to their appointment. Staff created a temporary set of notes for each patient including GP referral, nursing and consultant notes and previous electronic correspondence. These notes were then securely stored in the manager's office, until the patient's appointment, and then amalgamated with the original notes when they became available.
- We reviewed five sets of these patient notes, and all contained evidence of GP referral letters, copies of consultant's notes, consent for treatment and discharge letters. All were legible, signed with a printed name and dated.
- Patient health questionnaires were present in those notes where it was applicable.
- Location of notes was tracked on a shared computer drive. Staff told us they felt this was a good system and could not recall any issues tracking and obtaining patients' notes.
- The hospital did not record the number patients seen without all relevant medical notes being available, although outpatients staff could not recall a situation where this occurred.
- Transmission of all electronic patient information was via an encrypted route. If information was sent offsite, an encrypted transmission was used. This mitigated the risk of information being lost, and helped protect patients' confidentiality.
- Data provided by the hospital showed that some consultants and medical secretaries removed and stored medical notes off site. It also stated that any staff who did this were registered with the Information Commissioner's Office (ICO) and this was checked as part of the admitting rights to the hospital. This ensured note were transported, stored securely and destroyed in line with current legislation.
- The hospital carried out internal audits on medical records monthly. The most recent audit, that included outpatients' notes, was in April 2016 and scored 98%.
- Previous diagnostic images were requested in advance from the radiology team, ready for the clinic. There had been issues with retrieving images from the picture archiving and communication system (PACs), which were recorded on the hospital's risk register. However, staff felt that since an upgrade in June 2016, this was no longer of concern and could not recall issues in obtaining images since.
- The diagnostic imaging department held up to date records from the Health and Safety Executive (HSE). These confirmed they had registered their work with ionising radiations, a requirement of the Ionising Radiations Regulations 1999.

Safeguarding

- There were no safeguarding concerns reported to CQC during the reporting period July 2015 to June 2016.
- Safeguarding formed part of the hospital's mandatory training. Data provided by the hospital showed that 100% of outpatient and diagnostic imaging staff were up to date with safeguarding level two training for both adults and children. Department managers had received level three training which was up to date.
- The service followed up to date policies on safeguarding for both adults and children. They identified safeguarding leads, and outlined actions to take if staff had safeguarding concerns. Staff we spoke to had a good understanding of this policy and the hospital's safeguarding procedures. The safeguarding policy also contained guidance on female genital mutilation and domestic violence. There were flow diagrams on 'What to do if you think someone has been abused'. and a cause of concern, signs and symptoms report template.
- Staff we spoke to referred to an information card carried on their person, naming the safeguarding leads. Staff we asked could not recall the last time a safeguarding concern was raised in outpatients or diagnostic imaging. Therefore they felt there was no need to keep a safeguarding concerns register.

- The radiology department used a patient checklist in line with the World Health Organisation (WHO) guidelines. This helped keep patients safe, by ensuring the right patient had the right scan at the right time.

Mandatory training

- All staff commencing employment at the hospital completed mandatory training in line with hospital policy. This included, but was not limited to, data protection, health and safety, prevention of infection, manual handling and information security.
- The mandatory training policy stated that training must be completed annually. Data supplied by the hospital stated that 67.16% of outpatients and 62.07% of x-ray staff had up to date training. This was below the hospital's target of 85%.
- We discussed these figures with a member of the management team. The staff who were not up to date were bank staff who had not recently worked at the hospital. We saw clear plans for all current staff to complete their training on time. All outpatient staff we spoke to felt they had enough support and time to complete their training. Two members of staff gave examples of completing online training, as overtime at home, in order to keep up to date.

Assessing and responding to risk

- The department had a procedure if a patient became unwell during an appointment or in a controlled MRI area. This involved contacting the resident medical officer (RMO) who was available 24 hours a day and trained in advanced life support for both adults and children. There was also an emergency transfer protocol if the patient required transfer to an emergency department.
- The hospital had a service level agreement with a local NHS hospital to transfer patients, if necessary, to their critical care unit.
- The reception desks had call buttons for nurses and the crash team, a medical team that used the resuscitation equipment quickly to treat cardiac arrest. All staff we asked were aware of these procedures, and one stated they would also call 999 in an emergency.
- Emergency call bells were also present in diagnostic imaging treatment rooms. However, it was not clear where the call bell was in the changing cubicle, as there were three unlabelled buttons of the same size. We raised this with the department manager who addressed our concern immediately. We confirmed that all other call buttons were labelled and working.
- All outpatient staff had received up to date basic life support (BLS) training. Radiology staff BLS training levels were lower at 40%, again this was due to the data containing bank staff, who had not recently worked at the hospital.
- The hospital radiology department had introduced a 'pause check'; this allowed staff to do a double check on patients' name, address, date of birth, site of x-ray and previous imaging. This assured the correct patient and site of x ray, as well as preventing any unnecessary exposure to radiation.
- Entrances to diagnostic imaging had light boxes that lit when the rooms were in use. These stated 'controlled area x-rays, do not enter'. This helped keep people safe from unnecessary exposure to radiation.
- The radiology department had up to date risk assessments for the prevention of unnecessary exposure to radiation and the protection of both patients and staff. These included that of staff pregnancy and the transferring of patients.
- We saw evidence of patients completing screening assessments prior to having diagnostic imaging. One was for the identification of metallic items, such as pacemakers or piercings. This helped protect patients from harm when entering the MRI scanner's magnetic field. Another assessment helped protect patients from allergic reactions to contrast agent, a dye used in x-rays.
- Radiology had an 'anaphylaxis box' which was stored in the department office. This medication would be used if a patient went into anaphylactic shock caused by an allergic reaction to the contrast dyes used. We confirmed that this was always accessible and staff knew its location.
- The radiology manager was the hospital's designated radiology protection supervisor (RPS), whose duties included ensuring staff were fully trained and followed the latest guidance and legislation.
- The radiology department also had access to a radiation protection advisor (RPA). They were based at a London hospital, and available for advice, as well as performing yearly audits. A member of senior staff described them as very accessible and responsive.

- Pregnancy status of female patients was checked prior to receiving any diagnostic imaging. This was in line with the Royal College of Radiographers (RCR) guidelines. Notices were also on the entrance to diagnostic imaging rooms, advising patients to notify the radiographers if there was a chance they might be pregnant.

Nursing staffing

- The hospital employed a mix of registered nurses (RN) and healthcare assistants (HCA). Data supplied by the hospital prior to the inspection showed the outpatients department had 3.7 full time equivalent (FTE) RN's and two FTE HCA's.
- The radiology department employed three FTE radiographers and two FTE administration staff. The majority of staff worked on a part-time basis.
- Staffing levels and skill mix were planned, implemented and reviewed daily and the service undertook formal staffing reviews every six to eight months to ensure service delivery was safe. Department managers, and staff we spoke to, felt they had enough staff to provide a safe, efficient service. Data submitted by the hospital confirmed that staffing levels within outpatients and diagnostic imaging was stable. Sickness rates were variable and there was no vacancies or unfilled shifts between April and May 2016.
- The use of bank nurses in the outpatient department was higher than the average of other independent acute hospitals we hold this type of data for in the reporting period July 2015 to June 2016.This was because regular bank staff were utilised to maintain staffing levels without over recruiting.
- Staff told us the same members of bank staff were used each time. This enabled continuity of care and familiarity with the hospital surroundings. One member of staff said bank staff were experienced and felt they were part of the team.

Medical staffing

- The outpatients department was consultant led, using consultants who also worked at nearby NHS hospitals. At the time of our inspection, the hospital had 140 consultants working under practising privileges.
- A resident medical officer (RMO) was on site and available 24 hours a day. They were supplied by an external company who also provided relief RMOs if a rest period was required. The company checked daily to monitor the number of calls the RMO had received, and to ensure they were working within the time guidelines. The matron also met with the RMO daily to ascertain their workload. This ensured the RMO was able to fulfil their role safely. Staff spoke highly of the RMO, with no raised concerns.

Emergency awareness and training

- Each department had a green business continuity management folder with policies and guidance in the event of an emergency situation. We asked a member of outpatients staff about this, who was able to locate it immediately.
- We spoke to three staff regarding emergency planning, they gave examples of incident awareness scenario training sessions, run by the hospital. These included that of suspicious packages, loss of computer systems or use of the hospital's back-up generator.
- All outpatients and x-ray staff had up to date training on emergency management and fire safety. Fire extinguishers were available and all we checked had received up to date maintenance.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- Hospital policies were version controlled. This evidenced that policies were developed regularly. We noted that policies contained a table to highlight what additions had been made to the policy and when. An example of this was that the adult resuscitation policy had been updated in February 2016 when new national guidelines for resuscitation algorithms had been incorporated. Senior staff also received an alert from head office when a policy was updated.
- All policies were on the hospital's intranet page. One member of staff praised the alphabetical filing of these and stated they were easy to access. We asked for specific policies and they were retrieved immediately. We noted computer terminals in consulting rooms, reception and in offices. One member of staff stated 'there was always plenty of computers available'. Senior staff also printed off relevant polices, to provide hard copies in the staff break room.
- We reviewed policies relevant to outpatients and diagnostic imaging and found they were up to date and

well referenced. The Waiting list and management of patients accessing NHS treatment policy referenced The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and NHS England.

- The outpatient manager was working with the latest guidance from the National Safety Standards for Invasive Procedures (NatSSIPs) to update patient pathways.
- Assessments and advice on the outpatient's resuscitation trolley referenced good practice from the Resuscitation Council (RCUK) 2015 guidelines.
- Outpatients and radiology conducted internal audits specific to their department, for example, radiology conducted a rolling survey on 75% of all consultant referrals to x-ray, to ensure they were fully reported. There were no issues.
- Radiologists' reports were audited every three months, using an external company. The hospital sent a minimum of 10% of all reports for this audit, and ensured that this contained reports from all radiologists employed. The company would then re-report and grade the report on its quality. Senior staff said this was a very transparent process and all radiologists received specific feedback on their reports, and there had been no issues. We confirmed this by reviewing the audit from 15 December 2016. We noted that 96% (23) of reports had been rated five, the highest grade, with no issues. 4% (one) had grade four stating that this was due to reporting style rather than content. This audit also reviewed quality of the images submitted and found all to be of a high quality.
- All diagnostic images were quality checked before the patient left the department.
- Technology was used to enhance effective care. The outpatients department had implemented a barcode system for the decontamination of equipment. They could use this to track the equipment's location across different hospitals and hubs.

Pain relief

- Staff used an assessment tool to assess patients' pain using ratings of nought to three for mild pain, four to six for moderate pain, and seven to 10 for severe pain. If the staff observed any change in the nature of the patient's pain, they initiated a pain review by the prescriber, a registered nurse.
- If a patient was experiencing pain during an appointment, they would be assessed by the clinical team and pain relief offered where appropriate.
- Patients we spoke with had not needed pain relief during their attendance to the outpatient department.
- Pain relief advice was given following appointments. We reviewed the literature following a punch biopsy appointment. It contained contact numbers to call if the patient experienced pain. There was also advice on when to expect symptoms to decrease and what pain relief to take, if they wished.

Nutrition and hydration

- Water dispensers and vending machines were available, offering hot drinks and snacks, in the waiting areas. We witnessed reception staff assisting with these and ordering cup holders from the kitchen when required.
- Due to the transient nature of stays within the outpatient department, food was not offered as routine. There was however, a hospital café open to all patients and their visitors.

Patient outcomes

- The hospital participated in various audits including the national Patient Reported Outcomes Measures (PROMS), and local hospital based audits for example, infection prevention, protection and control, hand hygiene and medicines management.
- Local audits that scored less than 90% had an action plan for improvement. We confirmed this by reviewing the meeting minutes dated July 2016, which discussed focused training in order to improve audit results.
- The National Diagnostic Reference Levels (NDRLs) conducted regular audits to compare the average dose of radiation used to national levels. Senior staff confirmed there had been no issues with the audit results and we noted they were displayed within the department.

Competent staff

- All staff, including those on the bank, completed an induction and full training before commencing their role. All staff also had mandatory training requirements and clinical staff completed core skill competencies.
- New staff received a Ramsay risk management booklet, and this was reviewed at the end of the probationary period to ensure they had completed the required legislation training. This was in line with hospital policy.

Good

Outpatients and diagnostic imaging

- Data provided by the hospital stated that wider training opportunities existed for all staff to enable learning and innovation via the Ramsay Academy and local training sessions. Departmental heads identified individual professional development and training needs during the appraisal process. We confirmed that staff felt they had received sufficient training to perform their duties competently. One member of staff said that the hospital understood the importance of training, and requests for extra training were always agreed.
- All staff we spoke to felt competent to use equipment safely. One member of staff said they could access further training and help if they felt necessary. Each department had a Provision and Use of Work Equipment Regulations 1998 (PUWER) register to ensure staff were competent to use equipment. Department managers assessed and signed off equipment competencies for all their staff.
- We reviewed the internal appraisal audit showing that 88% of registered nurses and 100% of HCA's were up to date with appraisals. The hospital aimed for 100% for all staff. These were calculated on a rolling year basis dependent on start date. One member of staff felt appraisals were a good opportunity to discuss further training and had received assistance enrolling on a university course.
- Senior management told us poor performance was addressed at the time mistakes were made, and also discussed at appraisals. One member of staff confirmed that senior staff would talk through mistakes when they occurred; they went on to describe the process as positive, transparent and an opportunity to progress.
- Consultants were all registered by their professional body. Every consultant requesting practising privileges applied to the hospital and underwent an introductory interview with the general manager and matron. We confirmed they were also required to complete and submit a practicing privileges application form, copies of training certificates, references, evidence of indemnity insurance and GMC registration details.
- Medical appraisals were performed at the main employing NHS trusts for consultants with practising privileges. There was a process in place to ensure all consultants were up to date with the revalidation and practising privileges process.
- The hospital had 100% validation of registration for doctors with practising privileges in the reporting period July 2015 to June 2016. We saw evidence that the hospital would remove practising privileges if necessary and documentation that this had taken place in the months leading up to the inspection.
- We asked senior staff in radiology about training to administer radiation. They confirmed that if they had untrained staff, they would be supervised. However, at the time of inspection, all relevant staff were trained to use the equipment. This was in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and told us they worked together as a team.
- There were good working relationships with local trusts and service level agreements to support referral of patients between the hospitals. All comments by staff regarding the local hospitals were positive, they were described as accessible and responsive.
- The general manager told us about interdepartmental meetings where staff could discuss and solve issues between departments.

Seven-day service

- The outpatients and diagnostic imaging departments were open 8am to 9pm Monday to Friday and 8am to 3.30pm on Saturdays. The diagnostic imaging team provided a 24 hour on call rota to provide an out of hours service.
- The hospital used an offsite pathology service, that also provided an emergency and out of hours service.

Access to information

- Staff were able to access patient information such as x-rays, medical records and physiotherapy records appropriately through picture archiving and communication system (PACs) and paper records. Oaks Hospital planned to be one of the pilot sites within the Ramsay group for the implementation of electronic patient records, although there was no specific timeframe for this.
- There was a move towards contemporaneous notes which would eliminate the need for removal of notes from the site. However, only two out of the 140 registered consultants had signed up for this system. Administration staff told us that for the 138 remaining

consultants, their secretaries were contacted the week before the appointment to bring in the notes. Staff stated there was sometimes issues contacting consultant's secretaries, due to them being away, but there had been no issues in obtaining these notes on time.

- Staff had access to patients' records maintained by Ramsay Healthcare. These were securely stored in a cabinet in the nurse's office, or administration office. All staff had access to the electronic patient record system of consultant notes.
- Staff spoke highly of the shared computer drive, where they could track notes throughout the hospital.
- Notes were archived onto an external electronic system after three years. Administration staff confirmed they could always access these by requesting them via email.
- Digital images were stored and accessed via the hospital PAC system. . There was a secure process for sharing images via an image exchange portal, both internally within the Oaks and externally with NHS providers. Each member of radiology staff could log on, send, and receive images from any other care provider on the system. This allowed images to be ready in advance of the appointment if required.
- One member of staff described them as 'brilliant' and said they would just 'whizz information across' when required. Radiologists could then use the patient's previous images, preventing unnecessary radiation exposure.
- The hospital shared all relevant information with the patient's GP, we saw evidence of communication to and from GP's in all five sets of outpatient medical records we reviewed. Diagnostic imaging was also sent, the same day, via the hospital post room.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital worked to a policy titled Consent to treatment for competent adults and young people. We found this to be up to date and referenced national guidance. Staff we spoke to were able to explain the principles and importance of consent.
- There was evidence of signed consent in all five sets of outpatient notes we reviewed. The consultants had undertaken consent, risks were documented and both patient and clinician had signed appropriately in line with hospital policy.
- Staff could not recall a situation where a patient did not have capacity to consent. They were, however, able to explain the procedure if this was to occur, and what action they would undertake to ensure a patient's best interests assessment was completed.
- Staff had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguarding as part of their mandatory training. Staff we asked could access the relevant policies and could demonstrate an understanding of MCA and Deprivation of Liberty Safeguard guidance.
- Staff had information cards outlining the principles of MCA and Deprivation of Liberty Safeguards. We asked two members of staff about these, one was carrying it on their person, and another had it next to their computer monitor for ease of access. This enabled the staff to describe actions to take in the event of a MCA or safeguarding concern.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- Interactions between staff and patients were friendly and respectful during our inspection. We noted that patients were welcomed to the hospital and staff introduced themselves.
- The hospital received patient feedback via NHS Friends and Family Test (FFT). This is a mandatory test that compares care given across NHS providers. It helps hospitals understand whether their patients are happy with the service provided, or where improvements are needed. The hospital scored on average, 98% between January 2016 and June 2016. (This excludes data from March 2016 as this was not provided)
- The response rate for the FFT for NHS patients was below the England average (13% compared to 40%) Senior management in outpatients responded to this by producing cards on the reception desk, to hand out to patients reminding them to complete the FFT test. They believed this would see improvements in future response rates.
- Patients were given the option to be accompanied into the consultation rooms with their relatives. We

witnessed one patient who preferred to be accompanied by a relative in the waiting room, whilst another planned to take their relative in the consultation room with them.

- We observed patients being treated with dignity and respect. Consultation rooms had separate areas where patients changed behind closed doors. Diagnostic imaging had changing cubicles and curtains to protect patients' privacy and dignity during treatment.
- We saw evidence that the patient's confidentiality was protected. Consultations with medical and nursing staff took place in rooms with closed doors and could not be overheard. We witnessed staff knocking on doors, and awaiting an answer before entering.
- The hospital had a chaperoning policy and all staff were advised to explain the chaperoning procedure to patients when attending appointments and ask if the patient would like a chaperone in attendance during their appointment. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure.
- There was clear signage throughout, offering a chaperone, including on reception desks and on the television display. We also witnessed this discussion taking place with a patient and reception staff. Stamps were used in patients' notes to mark if they had accepted a chaperone or not.
- One patient we spoke to felt that discussions at reception were discreet. They were pleased that the receptionist read their referral letter rather than ask questions, the patient stated "it was nice that these discussions were kept private in a public waiting area".
- All three patients we spoke with had high praise for the care they received. One patient commented that all staff were very friendly, another said that staff were caring and made them feel relaxed. Whilst another said "I feel like it's a hotel, there is nothing I would change and I would recommend my friends and family here at the drop of a hat".
- We read a thank you letter that was sent to the department, the patient stated that they were "impressed by the professional and sympathetic manner of the staff", and they "left feeling greatly reassured and much happier than when they arrived".
- We witnessed a patient visiting staff at the outpatient reception desk with a present, thanking them for all they had done.

Understanding and involvement of patients and those close to them

- All patients we spoke with had arrived at the hospital with an understanding of their treatment, one stated they felt fully prepared. We witnessed staff taking time to explain the patient's treatment and asked if they had any questions. This kept the patient updated on their treatment and ensured they understood.
- We spoke to a patient following their appointment, they confirmed they had the opportunity to ask questions and were told when they could expect results. They stated that they felt unrushed and relaxed.
- One patient described their consultant as 'good at explaining treatment verbally'.
- Staff told us that private patients received copies of letters between the hospital and their GPs. We were unable to confirm this with any privately funded patients.
- Staff stated that patients were told if their expected consultant was unavailable prior to their appointment. All patients we spoke with saw their planned consultant.
- Staff and patients told us they were encouraged to take relatives in to appointments for support.
- During our conversations, staff were passionate about the support and care provided to their patients, one member of staff stated that they always put the patient's needs first.
- We observed patients being offered chairs and water. We witnessed staff ensuring patients were comfortable waiting, and helping those patients that were slow moving to their chairs.
- One patient informed us they were fully aware of the cost of the treatment before they arrived to the hospital. We heard a receptionist sensitively discussing costs over the phone, to ensure the patient understood.

Emotional support

- Staff were available to offer support and answer questions to address any patient concerns in relation to their care and treatment. One member of staff gave us an example of a senior nurse accompanying a patient for emotional support when they were receiving bad news.
- We also heard an example of when staff arranged additional support from a Macmillan nurse.
- One patient commented that they felt engaged in all discussion regarding their treatment.

Good

Outpatients and diagnostic imaging

- We heard an example of a patient wishing to see equipment before a procedure, which was organised by staff and helped ease some of their anxieties.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital had clear signage and provided free car parking, including disabled parking bays, which were located close to the hospital entrance. The hospital was also on a public transport route. One patient commented that they 'liked the parking arrangements and there was always plenty of space'.
- The reception desk contained information on opening hours, hospital policies, and information on costs. There were also magazines and newspapers available.
- Whilst hospital capacity was relatively low, there were no issues for patients to receive appointments and therefore flexibility and choice could be accommodated. Staff told us they would offer appointments to suit the patient when possible. All patients we spoke with were pleased with their appointment times.
- The hospital did not offer telephone appointments, although consultant advice was available via telephone, following an appointment.
- Information was provided in accessible formats. One patient was pleased with their appointment letter that contained their appointment time, named consultant, directions, maps and information on fasting.
- Another patient was also pleased that the consultant presented all the treatment options in writing, to take home, on the patient's request.

Access and flow

- There were 47,677 outpatient total attendances in the reporting period July 2015 to June 2016, 42% of these were NHS funded and 58% were other funded.
- There was an established process in place for monitoring compliance with NHS funded patients waiting less than 18 weeks for referral to treatment (RTT). The hospital met this target, with above 95% of patients waiting 18 weeks or less, in the reporting period July 2015 to June 2016.
- Staff stated that a predicted RTT breaches report was sent on a monthly basis to their clinical commissioning group (CCG) to inform them of any possible breaches for that month.
- The hospital had no patients waiting six weeks or longer from referral for the magnetic resonance imaging (MRI), computerised tomography (CT) or non-obstetric ultrasound diagnostic test.
- Patients could make appointments online or via their GP. We spoke to a patient who described booking online as very efficient and received a confirmation email straight way. Another patient, who booked through their GP, described the process as 'instant'. They felt their appointment was prioritised because of their condition and had been given an appointment time that suited their needs.
- Radiology services were planned around outpatient and theatre activity, and were available 24 hours a day. Staff told us appointments rarely ran late, however no data was recorded regarding this. On the day of our inspection, clinics appeared to run smoothly without lengthy waits for patients. All patients we spoke with confirmed their appointments were running on time.
- Whilst there was no oversight monitoring of missed appointments, the outpatient and diagnostic imaging department had an established process for following this up. When this occurred, secretaries would send out letters offering a new appointment time. If a patient missed an appointment three times, they were referred back to their GP. This ensured patients had the opportunity to re-attend if necessary.
- Patients received contact information following appointments, this enabled patients to access follow up advice if required. Follow up telephone calls were not made routinely to patients, as follow up appointments were often made on the same day. We confirmed with a patient that this was the case and they knew who to contact if they needed immediate advice.
- Outpatient staff coordinated their working arrangements dependent on consultant preference and clinical need. One example provided was that one consultant preferred to meet the patients from reception themselves, and the staff changed their working arrangements accordingly.

Good

Outpatients and diagnostic imaging

Meeting people's individual needs

- Patients were requested to complete a medical questionnaire prior to treatment at the hospital. This allowed specific patient needs to be identified, such as communication or special learning needs, and hearing or visual impairment, as well as medical needs such as allergies and medical history.
- Reception desks were at various heights to allow effective communication with those using wheelchairs. All services were on the ground floor, and a ramp was available to reach an outside diagnostic imaging unit.
- The hospital used a translation service for patients whose first language was not English. Translators could be booked to attend the hospital, or were available via a telephone service if required immediately. We noted a poster in the physiotherapy department, which staff used with patients to help identify their language.
- A hearing loop was available in reception areas for those hard of hearing.
- The hospital did not have specific lead staff for patients living with dementia or with learning difficulties. Staff stated that the number of patients attending the hospital with these conditions was relatively low. Data provided by the hospital demonstrated that all clinical staff received dementia training. All staff were aware of their responsibilities and would seek guidance from the manager or matron if they needed advice.
- The hospital could accommodate larger patients who had a BMI below 40. Staff identified patients with a high body mass index from the patient completed health questionnaire. They were then risk assessed for treatment. Larger seats were available in the waiting areas and radiology had a height adjustable couch, which could accommodate heavier patients.
- Staff provided patients with information leaflets specific to their treatment. We confirmed that these had contact numbers for any further questions the patient may have. We also saw this being pointed out to the patient when they received the leaflet.

Learning from complaints and concerns

- The hospital supplied data that showed there were 43 self-reported complaints across the hospital departments between July 2015 and June 2016. The Care Quality Commission (CQC) received three complaints in the same reporting period. A member of senior staff said that these were used to identify trends, and the majority were concerning financial arrangements for treatment.
- We heard of an example of a complaint regarding outpatient staff not knowing the patient's name on admission. We saw evidence that this was discussed at departmental meetings. Lessons were learnt and cascaded to staff via monthly newsletters. Staff were reminded to confirm the patient's name. We observed staff clarifying patients' details on arrival and at first introduction.
- There was a Management of complaint policy in place, which references guidance from the Department of Health, and legislation from the Health and Social Care Act 2012. This also included a ten-step process for handling complaints internally and information on external complaint processes. Staff we spoke to were aware of this policy and described the procedures to handle complaints.
- Complaints were reviewed weekly by the general manager, matron, and the quality improvement lead, and responded to as per the hospital policy. Lessons learnt and actions were shared at team meetings, and also disseminated via the monthly quality report.
- The general manager produced a 'hot alert' spreadsheet, which recorded patient concerns and complaints. This was sent to the heads of departments to action weekly, and used to identify any trends in complaints. A member of senior staff confirmed they received this update and spoke highly of this procedure.
- There was no patient information on display for the procedure for patients to complain. All three patients we interviewed said they had no reason to complain, but would raise issues at the reception desk if they had. Reception staff confirmed they would print complaint forms if requested. There was also a feedback form available in the waiting areas and on their website. This had a further comments section that could also be used for complaints.

Are outpatients and diagnostic imaging services well-led?

Good

Leadership and culture of service

Good

Outpatients and diagnostic imaging

- Outpatients and diagnostic imaging were led by individual heads of department (HoDs). They were reportable to the hospital's matron. Overall leadership of the service was from the hospital's general manager.
- The department leads were suitably qualified and experienced in their area of work. Both the outpatient and diagnostic imaging managers remained involved in the clinical work, enabling them to work with staff and be part of the team.
- All staff we interviewed spoke highly of the management team. One member of staff described the management as "very supportive" and stated "they could not do more for their staff".
- All staff we spoke to felt they could raise issues with management. They spoke of the general manager and matron moving their office to the main reception and having an 'open door' policy. Staff told us that this made senior managers more visible and approachable.
- Staff felt respected and valued. One member of staff said that: "management were always cheerful and it didn't matter your job role, everyone was made to feel important".
- There was a culture of openness and transparency; staff felt any issues or incidents were discussed honestly. One member thought this was because the departments were small and referred to their team as a 'small family'. Another member of staff felt fortunate that staff knew each other across departments, and again likened it to being part of the family.
- A member of staff we spoke to felt able to challenge other nurses and consultants if they felt necessary.
- Senior staff fed information down via departmental meetings, the staff notice board and monthly newsletters. One member of staff felt the process was open and felt informed about discussions at senior meetings.
- Leadership was discussed in meetings, for example, the heads of department meetings had a person responsible for all actions discussed. This was true for all minutes we reviewed (May, July and September 2016).
- We saw evidence of exchange of thank you and greeting cards amongst staff and patients. These were on display for all staff to read.

Vision and strategy for this this core service

- The Oaks Hospital had clear visions and values. They followed the Ramsay Healthcare UK values "The Ramsay Way" that was:
  - We are caring, progressive, enjoy our work and use a positive spirit to get things done.
  - We take pride in our work and actively seek new ways of doing things better.
  - We value integrity, credibility and respect for the individual.
  - We build constructive relationships to achieve positive outcomes for all.
  - We believe that success comes through recognising the value of people and encouraging that value through professional and personal development.
- Ramsay's commitments were integrity, ownership, positive spirit, innovation and teamwork. Staff told us the hospital shared these values and commitments and we saw these displayed in the hospital and on the web page.
- The Oaks Hospital used an individual, commercial and clinical strategy. This combined formed an overall hospital strategy to be the elective health care provider of choice.
- There was no local vision or strategy for outpatients and diagnostic imaging. However, staff we spoke with during our inspection were aware of these wider values and commitments.

Governance, risk management, and quality measurement

- There was a clear governance structure within the hospital. There were committees such as that for clinical governance (CGC), and regular meetings including that of senior management and heads of department. These all fed into the medical advisory committee (MAC).
- We reviewed the minutes for the meetings of the MAC, CGC and heads of department from November 2015, February 2016 and May 2016. They were well structured and included standard items on the agenda to ensure risk and quality oversight. These included policy updates, staffing levels, audit results and patient feedback.
- We reviewed the hospital's risk register; two risks were for diagnostic imaging. These were regarding accessing images on the PACs system following a computer malfunction in 2015. However, review of these risks had not been undertaken in a timely manner. We found that the risk register review date had passed five months

previously, in July 2016. We escalated this to the diagnostic imaging manager, who confirmed the risks should no longer be on the register, and the issues had since been resolved, following an update to the PACS system.

- The hospital's service level agreements were monitored and reviewed. This was evident in the September 2016 senior management team meeting, which discussed new SLAs for diagnostic imaging, and those that were due to expire.

Public and staff engagement

- Patient engagement was on the CGC meeting agenda. For example, the May 2016 minutes included evidence of ideas to engage and involve patients more by introducing a patient diary.
- There were plans for a patient user group that would meet every two months. The hospital stated that this aimed to provide a forum to share experiences, ensure the service reflects the need of the service, positively influence change and development and well as building better working relationships with the community. We noted that information on how to join this group was displayed on the hospital reception desk, as well as their webpage.
- The Oaks Hospital website welcomed feedback; they provided links to social media, NHS Choices and private healthcare review websites.
- Paper copies of feedback forms were available on the reception desk. This had open-ended questions, allowing patients to express themselves.
- The general manager personally answered, and sent thanks, to all comments made on the NHS Choices website and social media. The general manager had implemented a process called 'hot alerts'. This involved all comments being logged on a spreadsheet and passed to department leads. This enabled them to action and discuss comments relevant to their department.
- We reviewed a negative comment regarding outpatients on the NHS Choices website; the general manager informed the patient that this would be discussed in meetings and that they would carry out a full investigation and assessment. We confirmed with a member of outpatient staff that this had taken place.
- The general manager told us about a staff satisfaction group where staff could discuss issues and work life amongst each other. There was also a staff satisfaction survey. We reviewed the results from February 2016 and found satisfaction at the Oaks Hospital was higher than the average for Ramsay employees, in areas such as working environment, health and wellbeing, career development and communication. They scored slightly lower than the average in areas of pay, benefits and direct line management.
- Outpatient staff received a letter from their manager with their payslips. We reviewed the most recent, November 2016, letter. This contained updates on the service, reminders of new policies, invitations to department social events and an invitation to ask questions.

Innovation, improvement and sustainability

- Staff were actively engaged in seeking to improve and continuously learn. Examples included that of the chaperone arrangements. An external audit found that 83.3% of patients were offered a chaperone. The department introduced a stamp in patient notes, to act as a prompt for staff. They also introduced posters in each consultation room and a television display in the waiting area. The same research from November 2016 showed an improvement and 100% of patients had been offered a chaperone.
- Another example was that the waiting area was arranged following comments and suggestions from patients.
- The outpatient manager was also on the corporate clinical development committee, and currently working to improve the bowel preparation risk forms.
- The hospital was in the process of expanding its services by introducing a digital mammography room.
- Staff were awarded for customer service excellence, and employee of the month. Staff could nominate each other on a recommendation slip, and the winner would receive a gift voucher.
- Oaks Hospital celebrated being recognised as the winner of a regional award for newcomer SME of the year at the National Apprenticeship Awards in November last year. These awards challenge top apprenticeship employers and apprentices to show how apprenticeships have made a real difference in their organisations.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all actions identified for the Oncology service are completed and embedded. These were:

- Implementation of UKONS Oncology/Haematology 24 Triage Rapid Assessment and Access Toolkit, the completion of training for nominated staff.

- Contemporaneous health records for oncology patients including consent.

- Clear written protocols for all chemotherapy regimens and agents used.

- The provider should continue to work with staff in theatre to improve morale
- The provider should ensure that the new fluid and nutrition training is completed by all staff and that the new fluid charts are embedded and continue to monitor compliance.
- The provider should ensure that pre-operative starvation times are monitored to ensure that patients are not fasted for extended periods if surgery is delayed.