Ramsay Health Care UK Operations Limited

Fitzwilliam Hospital

Quality Report

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Date of inspection visit: 13 September 2017
Date of publication: 10/11/2017

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

Ratings

Overall rating for this hospital	Good
Surgery	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Fitzwilliam Hospital is operated by Ramsay Health Care UK. The hospital has 45 beds. Facilities include a two-bedded high care unit (HCU), three main theatres with laminar flow, a purpose built ambulatory care unit and a day case unit. The hospital provides surgery, outpatients and diagnostic imaging for adults.

We carried out a responsive inspection of surgery services in response to the number of serious incidents in gynaecological surgery reported by the provider between January 2017 and September 2017. We announced the inspection to the provider on the 6 September 2017 and carried out the inspection on the 13 September 2017and inspected the key question of safe in surgery only.

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

Services we rate

We rated surgery as good for safe and good for Well led.

We found good practice in relation to surgery:

- Staff understood their responsibility to raise incidents and concerns and the hospital had documented procedures for incident investigation and sharing of learning.
- Staff mandatory training and e-learning compliance was above hospital target (85%).
- The hospital was 100% compliant with intermediate life support (ILS) training.
- Staff knew their responsibility to safeguard vulnerable adults. Safeguarding training compliance was above the hospital target.
- The hospital had processes in place to manage risks to people. Risks were assessed, monitored and managed appropriately.
- Staffing levels and skill mix were appropriate and reflected patient acuity.
- The hospital had a clear governance structure in place with appropriate arrangements for communication. The hospital had committees such as clinical governance, senior management, and heads of department, which all fed into the medical advisory committee (MAC) and hospital management team.
- The theatre department and the ward had dedicated managers who reported to the hospital matron.
- Theatre and ward staff told us they felt valued and well supported by their manager. All the staff we spoke with told us that they were able to raise concerns openly and both managers had an open door policy.
- Staff knew the hospital vision was to be the number one provider of health care in the local area, and to offer high quality, safe, patient centred care.
- The hospital had a variety of mechanisms to gain feedback from patients by means of the friends and family test, monitoring social media comments, the online patient survey and through complaints and complements received.

We found areas of practice that require improvement in surgery:

- Two of the eight duty of candour letters the hospital had sent to patients who suffered serious incidents (SIs) were not accurate. One suggested “patient anatomy” to be the cause and the second did not detail why two procedures had been carried out when one would have sufficed.

Summary of findings

- Theatre staff we spoke with said they were not as well informed around previous incidents and their investigation outcomes despite incidents being a standard agenda item at weekly meetings.
- In theatre three anaesthetic room nursing staff recorded the room temperature to be 27°C. We reviewed room temperature records for theatre three anaesthetic areas. Theatre staff had recorded the temperature above 26 degrees on seven days in July, 13 days in August and 15 days in September. This is above recommended limits for storing medications and may impact on medicine efficacy
- The hospital did not keep records of conversations between the hospital general manager, the medical director (MD) and the MD at the local NHS provider regarding concerns around behaviour and performance of consultants.

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.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	We inspected surgery services in response to the number of serious incidents the reported by the provider in relation to gynaecological surgery between January 2017 and September 2017. We focused our inspection on surgery services and the domains “safe” and “well led.” Staff understood their responsibility to raise incidents and concerns and the hospital had documented procedures for incident investigation and sharing of learning. The hospital complied with duty of candour regulations in a timely way. Staff mandatory training and e-learning compliance was above the hospital target (85%). The hospital was 100% compliant with intermediate life support (ILS) training Staff knew their responsibility to safeguard vulnerable adults. Safeguarding training compliance was above hospital target. The hospital had processes in place to manage risks to people. Risks were assessed, monitored and managed appropriately. Staffing levels and skill mix were appropriate and reflected patient acuity. The hospital had a clear governance structure in place with appropriate arrangements for communication. The hospital had committees such as clinical governance, senior management, and heads of department, which all fed into the medical advisory committee (MAC) and hospital management team. The theatre department and the ward had dedicated managers who reported to the hospital matron. Theatre and ward staff told us they felt valued and well supported by their manager. All the staff we spoke with told us that they were able to raise concerns openly and both managers had an open door policy. Staff knew the hospital vision was to be the number one provider of health care in the local area, and to offer high quality, safe, patient centred care.

Summary of findings

The hospital had a variety of mechanisms to gain feedback from patients by means of the friends and family test, monitoring of twitter and Facebook comments, the online patient survey and through complaints and complements received.
However,
Two of the eight duty of candour letters sent to patients were not accurate, one stating patient anatomy as a cause and the second not describing why two procedures had been performed when one should have sufficed.
Theatre staff we spoke with said they were not as well informed around previous incidents and their investigation outcomes despite incidents being a standard agenda item at weekly meetings.
In theatre three anaesthetic room nursing staff recorded the room temperature to be 27°C. We reviewed room temperature records for theatre three anaesthetic areas. Theatre staff had recorded the temperature above 26 degrees on seven days in July, 13 days in August and 15 days in September. This is above recommended limits for storing medications and may impact on medicine efficacy
The hospital did not keep records of conversations between the hospital general manager, the medical director (MD) and the MD at the consultant's substantive NHS provider regarding concerns around behaviour and performance of consultants outside of the annual appraisal process.

Fitzwilliam Hospital

Detailed findings

Services we looked at
Surgery

Detailed findings

Contents

Background to Fitzwilliam Hospital

Fitzwilliam Hospital is operated by Ramsay Health Care UK. The hospital opened in 1983. It is a private hospital in Peterborough, Cambridgeshire. The hospital cares for adults aged 18 years and over from the communities of Peterborough and the surrounding area. The hospital no longer offers care to children.

The hospital is registered to provide the regulated activities of:

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

The hospital has had a registered manager in post since 1 October 2010.

We inspected surgery services in response to the eight serious incidents and two never events reported by the provider between January 2017 and September 2017. We focused our inspection on surgery services and the domains “safe” and “well led”.

We previously inspected this service in December 2016 and issued the provider with one requirement notice along with some actions the provider should take in order to improve services. The requirement notice related to services for children and young people in surgery.

We agreed an action plan with the provider as a result of the requirement notice from the previous inspection (December 2016). The provider had completed three out of four actions and the remaining action was ongoing. We were satisfied with the progress the provider had made against the action plan.

Our inspection team

The inspection team comprised a CQC lead inspector, two CQC inspection managers and a specialist advisor with expertise in gynaecology. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Facts and data about Fitzwilliam Hospital

Fitzwilliam Hospital is a purpose-built hospital with three main theatres with laminar flow, a purpose-built ambulatory care unit and a day case unit with general anaesthetic facility.

The hospital has benefited from a proactive investment programme totalling in excess of £6m in the last five years. A further major development was approved and work commenced in October 2016 for an additional main theatre, theatre equipment store, refurbished physiotherapy department with a larger gym facility,

Detailed findings

three additional new outpatient clinic rooms, a new two-bedded higher care unit (HCU), and further development to the reception waiting area, additional administration space, and patient parking.

During the inspection, we visited theatres, recovery area and the ward. We spoke with 20 members of staff including; surgeons, anaesthetists, registered nurses, health care assistants, housekeeping, operating department practitioners, and senior managers. We spoke with three patients. During our inspection, we reviewed five sets of patient care records and eight serious incident (SI) investigations.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in December 2016. The provider was not meeting all standards of quality and safety it was inspected against. We issued the provider with one requirement notice, relating to the treatment of children under 18 years of age, along with some actions the provider should take in order to improve services.

Activity (January 2017 – July 2017):

- Total hospital activity 42,241 (including outpatient activity)
- There were 6506 inpatient episodes of care recorded at the hospital
- Of these, 306 (4.7%) were gynaecology activity.

There were 159 consultants practising at the hospital under practising privileges. There were 64 full time equivalent (FTE) registered nursing staff; 36 FTE health care assistants (HCA), six operating department practitioners (ODP). There was a resident medical officer (RMO). The accountable officer for controlled drugs (CDs) was the registered manager as of January 2016.

Track record on safety January 2017 to July 2017:

- Two never events
- Eight serious incidents (SI)
- 262 clinical incidents; 197 with no harm, 46 low harm, and 19 moderate harm.
- No incidences of hospital acquired (MRSA)
- 12 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:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement:

- Pharmacy
- Blood Bank
- Histopathology
- Infection Control Chair
- Pathology

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	N/A	N/A	N/A	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Surgery

Safe	Good
Well-led	Good
Overall	Good

Information about the service

Summary of findings

Surgery

Are surgery services safe?

Good

We rated safe as good.

Incidents

- We inspected surgery services in response to the eight serious incidents (SIs) and two never events the service had reported as a result of surgery in the period January 2017 to September 2017. We focused our inspection on surgery services and the "safe" and "well led" domains.
- The hospital reported two never events in surgical services during the period January 2017 to July 2017. A never event is a serious incident that is wholly preventable as guidance or safety recommendations that provide strong protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Both never events were wrong site spinal surgery. Hospital management investigated both incidents and took immediate action to eliminate the cause and prevent further incidents of this type occurring. The never events were both due to a clearly identifiable cause and not related to the other eight serious incidents (SIs). The action the hospital had taken assured us this would prevent further incidents of wrong site spinal surgery.
- The hospital reported eight serious incidents (SIs) in the reporting period January 2017 to July 2017 with an additional three SIs in August 2017. The initial eight SIs related to perforations of bladder, uterus or colon during gynaecological procedures.
- The hospital investigated all SIs at the time they were reported and tried to identify trends and themes. The hospital identified that one surgeon was responsible for three of the SIs and another surgeon was responsible for two. We reviewed the incident investigations for all eight SIs. Investigations included root cause analysis, statements from the surgeon and the theatre team.
- The general manager at the hospital, the medical director (MD) and the MD at the consultant's substantive NHS provider had discussed the consultants involved to gain a thorough understanding of the consultants' complication rates and share concerns. These were informal conversations and were not recorded.
- The hospital management held meetings with the commissioning group (CCG) which had referred patients for surgery. We spoke with the CCG who confirmed they had been aware of SIs at the hospital and had also visited the hospital.
- The hospital sought the advice of the medical advisory committee (MAC) chairperson along with the director of nursing and the medical director who reviewed the SIs with the aim of identifying any trends.
- The hospital had commissioned the Royal College of Gynaecologists (RCOG) to review practices and processes where SIs had occurred to ensure all possible precautions to prevent SIs were in place. The review was due to take place in December 2017.
- During the inspection, our specialist advisor (SPA) reviewed the eight SIs and concluded that two of them were due to unexpected intraoperative complications, two were expected intraoperative complications due to the complex nature of the patients' medical condition and four were due to sub optimal surgical technique.
- Two surgeons were identified as having sub optimal surgical technique. The hospital had already suspended one of the surgeons operating pending external review and the second surgeon no longer practices medicine in the UK.
- We were assured that the hospital had taken all appropriate action to investigate and learn from the SIs and never events and had taken appropriate action against the surgeons involved to ensure that patients undergoing operations in the hospital in future were safe.
- All staff had access to an electronic incident reporting system. The provider had an incident reporting policy for staff to follow which outlined staff responsibilities and risk classification. Staff knew what was considered to be an incident and how to report it.
- The hospital reported 262 clinical incidents in the reporting period January 2017 to July 2017, 197 were no harm, 46 low harm and 19 moderate harm.

Surgery

- All the ward staff we spoke with knew of previous incidents. Ward managers shared incidents at team meetings and staff unable to attend meetings received a copy of the minutes with their pay slip. We reviewed the minutes of the ward meetings dated April, June, and August 2017 and incidents was a standing agenda item.
- Theatre staff we spoke with said they were not as well informed around previous incidents and their investigation outcomes despite incidents being a standard agenda item at weekly meetings. Two staff told us that if they were not present for the meeting they would not be aware of what had been discussed.
- We observed changes in practice as a result of learning from incidents in the form of marking patients twice to identify the site of surgery, once by the anaesthetist and once by the surgeon, using different colour pens.
- Nursing staff we spoke with knew the duty of candour policy. 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.
- A large poster describing the duty of candour policy was displayed on the wall in the ward area and there were letters to patients in line with the duty of candour regulation in the eight SI investigations.
- During the inspection our SPA considered the duty of candour letters and was of the opinion that two letters sent to patients detailing the incident investigation and identified causes were not wholly accurate siting patient anatomy as a cause and not describing why two procedures had been performed when one should have sufficed.
- Patient mortality was a standing agenda item at the Medical Advisory Committee (MAC) meeting. Minutes of the MAC meetings from February, April and July 2017 showed this.

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

- The hospital displayed clinical quality data and safety thermometer data in the ward staff room. The safety thermometer for August 2017 showed 100% "harm free" patient care. This means the patients in the hospital had no pressure ulcers, no falls with harm, no catheter infections and 100% compliance with venous thromboembolism (VTE) risk assessment completion.
- Data provided by the hospital showed 100% harm free care for the reporting period January 2017 to July 2017.

Cleanliness, infection control and hygiene

- At our previous inspection (December 2016) we had identified areas of concern relating to surgical site infection rates.
- Hip and knee surgical site infection (SSI) rates had improved since our last inspection (December 2016). Between July 2016 andJune 2017 the hospital had six hip infections out of a total of 366 replacements (1.6%)and eight knee infections out of 474 replacements (1.7%) compared to 2.9% and 4.1% respectively from the previous inspection (December 2016). While this shows an improvement, the hospital SSI rates are still higher than the national average of 1.1% for hip replacements and 1.4% for knee replacement during the same period.
- Nursing staff wore uniforms and followed the "bare below the elbows" policy. In addition, staff wore gloves and aprons appropriately while providing patient care and disposed of these correctly.
- All ward areas were visibly clean, tidy and uncluttered.
- Staff had access to an infection prevention and control policy and in addition hand hygiene, and MRSA screening policies were available to staff on the hospital intranet.
- During the reporting period January 2017 to July 2017, the hospital reported no incidences of hospital acquired MRSA but had 12 incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA); two cases were reported each month in January, April, May and June, three cases in February, and one case in July. The hospital infection prevention control committee investigated the infections in order to identify the cause and reduce any identified risks. The actions identified included additional staff training and improved patient swabbing techniques.

- During the same period, the hospital reported no incidences of hospital acquired Clostridium difficile (C.difficile) and no incidences of hospital acquired E-Coli.
- Nursing staff swabbed patients for the presence of MRSA and MSSA at their pre-operative assessment.
- We observed staff washing their hands before and after providing care to patients and using hand-sanitising gel appropriately.
- We reviewed hospital hand hygiene audit data. In April 2017, the hospital management had introduced a more robust audit process in response to hand hygiene audits consistently showing 100% compliance. Compliance in April 2017 was 40%, which increased to 90% in March, fell to 80% in April before rising to 100% in June. Actions taken as a result of the audits included speaking to staff and re distributing the hand hygiene policy.
- Nursing staff cleaned equipment on the ward and placed a dated green sticker on all items after cleaning. We inspected three blood pressure monitors; they were all visibly clean and displayed the "I am clean" sticker.
- Housekeeping staff checked mattresses for signs of wear and tear daily. Mattress checking records from the beginning of September 2017 showed no omissions.
- Housekeeping staff cleaned bedrooms daily and records from the beginning of September 2017 confirmed this.
- Housekeeping staff changed disposable bathroom shower curtains every six months and the date of last change was clearly written on them.
- We reviewed the hospital "Steam deep clean log/ schedule 2016/2017" which showed all bedrooms and ward areas had received a deep clean. Communal areas, such as corridors were steam cleaned on a three monthly basis.
- The hospital had a service level agreement with another Ramsay hospital for the decontamination of surgical instruments. The theatre staff had the ability to track surgical instrument cleaning electronically through the barcoded system in place. The hospital had two deliveries of decontaminated equipment and two collections of contaminated equipment per day.

Environment and equipment

- Nursing staff cared for patients in ensuite single occupancy bedrooms. All rooms had telephones, wall mounted televisions and cupboards to store patient belongings. The hospital had 14 bedrooms for privately funded patients and 26 bedrooms allocated to NHS patients. The bedrooms for privately funded patients were to a higher specification, with carpet flooring and more storage for patient belongings.
- Hospital cleaning records showed housekeeping staff hoovered bedroom carpets on Mondays, Wednesdays, Fridays and between patients and carried out deep cleans with shampooing annually or when required, after infection for example.
- Resuscitation trolleys were available in the theatre recovery and in the ward. The resuscitation trolleys were sealed with a breakable tag with a unique identification number which was recorded in the records.
- We inspected the daily check records for the ward resuscitation trolley and found staff had completed all checks without omission for the months June, July and August 2017. Staff had recorded dates of when equipment had been changed or replaced. Staff carried out daily and weekly checks on the resuscitation trolley stored in recovery area. All records had been completed with no omissions for June to September 2017. All equipment stored on the trolleys was stored appropriately and in date for sterility.
- We inspected the difficult intubation trolley. Staff carried out appropriate checks and completed records with no omissions between June and September 2017.
- Theatre equipment was serviced and tested for electrical safety within appropriate time frames. However, centrally held equipment maintenance records had not been updated to reflect this. We raised this at the time of inspection and the provider updated the records immediately.
- The near patient testing blood machine had been serviced and records showed staff had completed biweekly quality checks without omission for the six months prior to our inspection.
- Staff stored equipment such as hoists and drip stands in the inpatient storeroom. Equipment was labelled as clean. We inspected six syringe drivers and all had been serviced and undergone appropriate electrical testing.

Surgery

- Both sluice rooms were visibly clean and tidy. Nursing staff labelled commode seats with "I am clean" stickers and stored them on shelves.
- All staff followed good waste segregation processes using different coloured bags for different types of waste. Staff labelled sharps containers correctly and did not overfill them.
- The hospital had a tracking and traceability process for recording medical implants used during surgery. There was an implant register in theatres and staff applied the relevant barcode from the implant into the patients care records.
- In theatre three anaesthetic room, on the day of inspection nursing staff recorded the room temperature to be 27°C. We reviewed room temperature records for theatre three anaesthetic areas. Theatre staff had recorded the temperature above 26 degrees on seven days in July, 13 days in August and 15 days in September. This is above recommended limits for storing medications and may impact on medicine efficacy. The theatre temperature was recorded to be at optimal operating temperature on all records.
- Staff had reported the elevated temperature to the pharmacy department and the senior management team in June 2017 and at the time of inspection. The hospital had carried out at risk assessment and the risk was recorded on the hospital wide risk register. The hospital planned to replace the air conditioning unit in March 2018 other actions to mitigate the risk included not storing medicines in the anaesthetic room on the days the room temperature was raised. Theatre staff recorded on the room temperature log when they had removed drugs to a cooler area.
- However, during our inspection we observed a patient who had undergone spinal surgery was delayed returning to the ward as nursing staff were unable to get the dressing to stick over the surgical site because the patient was sweating.

Medicines

- The hospital kept medicines in rooms secured with a keypad entry system in both the ward and the theatre department. Controlled drugs were kept in double locked metal cupboards in the anaesthetic room of each theatre.
- Nursing staff stored medicines required for the theatre list of the day in the relevant theatre anaesthetic room. Nursing staff did not store medicines in theatre three anaesthetic room on days when the room temperature was greater than 25 degrees. Instead, nursing staff returned medicines to the main store and collected the medicines required immediately prior to each patient entering theatre.
- We reviewed the controlled drugs record book all records were complete and correct.
- Nursing staff checked and recorded medicine fridge temperatures daily. There were no gaps in recordings for the three months prior to inspection and temperatures remained within acceptable limits.
- We reviewed a sample of medicines, all were within date and stored correctly. Nursing staff explained how the hospital pharmacist visited the ward on a daily basis to review medicines.
- We reviewed a sample of intravenous (IV) fluids and enteral feeds. All were within use by date and stored correctly.
- Medication charts were present in all five patient records we reviewed. Nursing staff recorded the patient's allergy status and the name, the dose, the time and the route of administration on medication they administered before signing the medication record.

Records

- The hospital only used paper patient records and no patient records were kept electronically. Staff kept legible accurate contemporaneous records and used paper patient pathway documents to record the inpatient care provided.
- All inpatient medical records were kept within a labelled metal rack in a room secured with a keypad entry. Patient nursing care records were kept at the patient bedside in closed folders.
- We reviewed five patient care records and all had documented pre-operative assessment records completed at a nurse-led pre-operative assessment.
- Within the five patient records, we found that staff completed risk assessments for falls, pressure ulcers and malnutrition universal screening tools (MUST). Staff

also completed venous-thromboembolism (VTE) risk assessments. This was an improvement on our previous inspection findings (December 2016) where not all surgery patients had received a VTE risk assessment.

- Staff completed the World Health Organisation (WHO) five steps to safer surgery checklist and this was seen in all five patient records we reviewed. The checks were undertaken in theatre and in accordance national guidance. All traceability records were also visible in all five records checked.

Safeguarding

- Data provided by the hospital during the inspection showed that staff completed all safeguarding training through e-learning.
- The hospital wide training completion rate for safeguarding adults level one was 98% and level two was 95%. Safeguarding adults level two training included Deprivation of Liberty Safeguards (DoLS) training and PREVENT (counterterrorism).
- Although the hospital did not treat children, 96% of hospital staff received safeguarding children level one training and 89% level two (hospital target 85%). This meant staff had training and awareness of any potential safeguarding issues which may arise when children visited inpatients.
- Safeguarding staff notice boards were on the ward and within the staff rest room in the theatre department. In both areas, the noticeboards displayed comprehensive information relating to safeguarding adults and children. Safeguarding flow charts were available to guide staff through the local process of raising a safeguarding concern.
- We spoke with four members of nursing staff about safeguarding. All the staff members knew how to raise a safeguarding concern, referred to the notice boards and could give examples of types of safeguarding concerns they would raise to their manager.

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

- The staff mandatory training programme included fire training, basic life support, manual handling, blood transfusion, infection control with aseptic non-touch technique, immediate life support, risk management, PREVENT (counterterrorism) and customer care.
- In September 2017, hospital wide e-learning compliance was 92% and hospital wide mandatory training compliance96% which was above the hospital target of 85%.
- The e-learning completion rate for all ward staff was 91% which was above the hospital target of 85%. This was an improvement on our previous inspection findings (December 2016) where the e-learning mandatory training completion rate for inpatient services was 69%. The e-learning mandatory training completion rate for the theatre department was 86%.
- In September 2017, the mandatory training completion rate for ward nurses was 99% and 98% for healthcare assistants .This was an improvement on our previous inspection findings from December 2016 where registered nurses achieved 88% compliance and healthcare assistants 93%.
- In September 2017, mandatory training completion data for the theatre department showed overall compliance was 90%. The completion rate for operating department practitioners was 93%, this was increased from 86% at previous inspection of December 2016. Mandatory training completion data for registered theatre nurses was at 92%, increased from 85%, healthcare assistants was 83%, increased from 81%. This showed an overall improvement however, this staff group was still below the 85% hospital target.
- We spoke with three members of nursing staff about mandatory training and all of them said they had completed their mandatory training and there were no problems accessing e-learning or mandatory training. Hospital mandatory training records confirmed this.

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

- The hospital had an admission criteria for patients and all patients underwent a pre-operative assessment to ensure only low risk healthy adults underwent surgical procedures. We reviewed the admission criteria and the pre-operative assessment checks and had no concerns.

Surgery

- 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 such as heart rate. We reviewed five patient records and in all cases we found that staff completed the NEWS score appropriately.
- The hospital had a formalised document for nursing staff to complete at the time of escalating a deteriorating patient, this was used in conjunction with NEWS and included analysis of the situation, patient background, assessment and recommendation (SBAR).The completed document was inserted into the patient record, nursing staff knew how to complete the document and how to contact the resident medical officer (RMO) to review a patient of concern.
- All the nursing staff we spoke with could describe the procedure to follow in the event of a deteriorating patient or a patient showing signs of sepsis. Nursing staff could describe the steps to follow in the event of suspecting sepsis and there was a "sepsis flow chart" in each patient nursing record as an aide memoire.
- The hospital had access to a RMO 24 hours a day, seven days a week in the event of an emergency. In addition, consultants remained on-call until their patients were discharged from the hospital. In the event of deteriorating health of a patient, staff would call upon the RMO as per hospital policy.
- The hospital had a service level agreement with another Ramsay hospital for the transfer of an unwell patient who required intensive care. The hospital had a policy for the transfer of a critically ill adult which contained checklists for staff to use to ensure the process was followed correctly.
- The hospital had introduced a "double marking" system (June 2016) to prevent wrong site surgery never events. The anaesthetist marked the site of surgery on the patient in red marker and the surgeon marked the patient in black to identify the correct area for surgery.
- The hospital used the World Health Organisation (WHO) five steps to safer surgery and we reviewed correctly completed checklists in all five patient care records we reviewed.
- We observed staff complete the WHO five steps to safer surgery checklist in theatre for two patients and all elements were carried out correctly on both occasions.
- Theatre staff carried out a monthly WHO audit. The audit from July 2017 showed 100% compliance. We reviewed a random selection of 10 WHO checklists from July, August and September 2017 and saw all 10 were completed correctly.
- Theatre sessions were two per day, morning session 8.15am until 12.30 and afternoon session 1pm until 4.30 pm or 5pm. There were 98 sessions between January and July 2017. With 412 gynaecological procedures this meant an average of 4.2 procedures per session.
- Theatre lists consisted of a combination of a number of minor procedures and one or two major procedures depending on time required to complete the procedure. The hospital managed theatre utilisation to ensure there was not excess pressure on theatre staff to operate on more patients than was safe.
- The hospital undertook cosmetic surgery procedures and had measures in place to ensure patients had access to a psychological assessment if this was required. The hospital employed two specialist cosmetic surgery nurses qualified to undertake these assessments.
- In September 2017, the completion rate for basic life support training for the ward and theatre department staff was 98% which had improved from 86% at previous inspection (December 2016), the hospital target was 85%. In addition 100% of ward and theatre staff had completed intermediate life support (ILS) training.
- In September 2017, the completion rate of advanced life support training (ALS) for theatre staff was 80% and completion rate for intermediate life support (ILS) training was 100%7.
- We reviewed five patient care records and all of the patients had attended a pre-operative assessment. Nursing staff had completed a pressure ulcer risk assessment, the malnutrition universal screening tool (MUST) assessment, a venous thromboembolism (VTE) risk assessment and health screening for each patient.

Nursing and support staffing

Surgery

- The ward manager planned staffing levels according to a local staffing tool giving consideration to patient acuity and staff skill mix. Nurse staffing was one registered nurse (RN) to seven patients with the support of a health care assistant (HCA).
- The hospital nurse shift pattern included an early shift 7am until 3pm, late shift 1pm to 9pm and night shift 8pm to 7.30am. Two nurses worked on the early shift when patients were pre-operative and this increased to three nurses in the afternoon when patients' acuity increased due to requiring post-operative care.
- The ward staff held handovers at each staff shift change, 7am, 1pm and 8.30pm, to discuss patient care needs. Each patient had a named nurse to enhance continuity of patient care.
- The hospital employed two specialist cosmetic surgery nurses.
- The hospital employed 64 registered nurses (RN) and 36 HCAs between the ward and theatres. The ward and theatre areas were not at establishment for staffing. There were 2.5 full time equivalent (FTE) RN vacancies and one FTE HCA vacancy.
- The hospital used eleven bank nursing staff including HCA's and regularly employed agency staff in theatre during the period January 2017 to August 2017.
- The required theatre staffing and skill mix was three surgical first assistant (SFA) or scrub nurses with one health care assistant (HCA) and one operating department practitioner (ODP) per theatre. Nursing staffing was appropriate for the surgery being performed.

Medical staffing

- The hospital had a documented process for the selection of consultants to award practicing privileges. The process involved interviews by the medical director for the hospital along with a paper review of the consultant's previous performance and expertise by the local Medical Advisory Committee (MAC) made up of experts in specific surgical fields.
- The resident medical officers (RMO) were on-call 24 hours a day for urgent calls. The RMO worked to a rota of seven days of 24-hour cover followed by seven rest days.
- The RMO received a handover briefing at the beginning of their shift which highlighted any patients of concern or tasks for the RMO to complete during the shift.
- Consultants remained on-call for the duration of their patients inpatient stay in hospital. In addition, the consultant arranged cover using a "buddy system" for any holiday and other leave to ensure patients had a nominated consultant to oversee their care.
- Anaesthetists attending to patients during their procedure remained on-call for 24-hours following the surgery in case of an emergency. Anaesthetist cover was by a rota system.

Emergency awareness and training

- The hospital had a business continuity plan dated January 2016, due for review in January 2020. The plan described steps the hospital would take in the event of a major incident or disaster to reduce the impact on patient care.
- The hospital worked through major incident scenarios such as civil disturbances, severe weather and fire drills as "table top" exercises. The last scenario was carried out in August 2017 and was found to be satisfactory.
- The hospital tested fire bells weekly. All fire extinguishers we checked were easily accessible, correctly secured and tested.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The hospital matron and the general manager had good oversight of the surgery service due to regular visits to ward and theatre areas.
- The theatre department and the ward had dedicated managers who reported to the hospital matron. A deputy theatre manager and a theatre co-ordinator supported the theatre manager and ward sisters and a senior staff nurse supported the ward manager.

- The theatre and the ward manager told us that they felt well supported by the hospital matron who was very visible to staff. All the nursing staff told us that they felt they could approach the matron if they had any concerns.
- Theatre and ward staff told us they felt valued and well supported by their manager. All the staff we spoke with told us that they were able to raise concerns openly and both managers had an open door policy.
- The hospital had a positive reporting culture around incidents. The hospital were open and honest with the Care Quality Commission (CQC) and the local commissioning group (CCG) around the eight serious incidents (SIs) and the two never events.

Vision and strategy for this core service

- The service worked to the corporate 'Ramsay Way' which was an overarching strategy. Staff knew the hospital vision was to be the number one provider of health care in the local area, and to offer high quality, safe, patient centred care.

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

- The hospital had a clear governance structure in place with appropriate arrangements for communication. The hospital had committees such as clinical governance, senior management, and heads of department, which were held monthly and all fed into the medical advisory committee (MAC) and hospital management team.
- We reviewed the meeting minutes of the MAC meetings dated February, April and July 2017. The majority of key specialities attend the meetings including representatives from orthopaedics, urology, plastic surgery, gynaecology and general surgery. Items discussed included, but were not limited to, incidents, mortality, risk register, audits and the clinical governance report along with any items escalated from other groups or committees.
- Heads of department attended the clinical governance committee meetings and held a heads of department meeting monthly where they cascaded information to their team members. We reviewed the clinical governance reports from January 2017 to July 2017. Agenda items included but were not limited to incidents, infection prevention and control (IPC), safeguarding and risks.
- The clinical governance committee report for January, February and March 2017 included details of the three SIs which had occurred during the three months. The minutes of the clinical governance committee meeting dated April 2017 evidenced the SIs had been identified, discussed and learning shared with staff.
- The meeting minutes of the MAC meeting dated April 2017 evidenced the clinical governance report had been shared with the MAC and the SIs had been discussed with input from the MAC representative for gynaecology.
- Heads of department held team meetings monthly. We reviewed ward team meetings dated April, June and August 2017. Set agenda items included incidents, training, IPC, staffing.
- The hospital infection control committee analysed any reported infections to identify trends and themes. The committee had carried out environmental audits and introduced an action plan to reduce the number of infections.
- The bookings manager held an operational planning meeting every week where the ward manager, radiology and theatre managers reviewed the theatre lists. At this meeting, lists were amended if required to reflect procedure complexity. The booking manager and the theatre manager along with speciality leads where appropriate, were responsible for the generation of theatre lists ahead of the planning meeting.
- Governance information was displayed on governance information boards across the hospital. Information displayed on the boards included information on the previous month's complaints, incidents, trends, actions, audits, infections, satisfaction results, training statistics, and any relevant policy changes.
- The hospital general manager (GM) and medical director (MD) shared information of concern with the MD at the consultant's substantive NHS provider. For example, the GM and the MDs discussed concerns around the consultants involved in the eight SIs. However, there were no records kept of these conversations.

Surgery

- The hospital had a process for consultant selection and awarding of practicing privileges. The consultant initially made contact with the hospital in writing with their curriculum vitae (CV). The application was reviewed by the hospital general manager. Suitable applicants were invited to attend interview with the hospital general manager before attending interview with the MAC. The medical director made the final decision. The hospital carried out background checks on successful applicants and consulted with the consultant's substantive employer or employing NHS provider around complication rates for example, before offering the consultant practicing privileges.
- Consultant annual appraisal was carried out by the consultant's responsible officer who was based at their employing NHS trust. The hospital provided the responsible officer with the consultant's activity logs detailing numbers of procedures, types of procedures, complaints, serious incidents (SIs) and infection rates.
- All the consultants who had been responsible for the eight SIs had received an annual appraisal without cause for concern being identified by the provider.
- We reviewed the hospital complication rates for the consultants responsible for the eight SIs. Complication rates (%) are derived from the number of complications per total number of procedures carried out at the hospital and do not take in to account the number of procedures carried out by the consultant in their substantive NHS post. For one consultant this was one complication in 84 procedures (1.19%), the second consultant had one complication in 91 procedures (1.10%), the third consultant had two complications in 506 procedures (0.40%). One other consultant had a higher complication rate (9.09%) which was due to one complication in 11 patients.
- Each department had a local risk register. The clinical governance committee discussed any local risks which scored over 12 and these were added to the hospital wide risk register along with any control measures in place to mitigate it. We saw this was true for the elevated room temperature in anaesthetic room three.

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

- The hospital had a variety of mechanisms to gain feedback from patients by means of the friends and family test, monitoring of social media comments, the online patient survey and through complaints and complements received.
- The hospital held education events on the first Thursday and third Wednesday every month for local general practitioners (GP's) with presentations from consultants on a variety of health topics.
- The hospital also held open events for the public with consultant speakers about procedures offered by the hospital.

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

- Work was on-going at the hospital to create an additional main theatre, theatre equipment store, refurbished physiotherapy department with a larger gym facility, three additional new outpatient clinic rooms, a new two-bedded higher care unit (HCU), improve the reception waiting area, and create additional administration space and additional patient parking.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The hospital should ensure all duty of candour letters sent from the hospital to patients are accurate. Two of the eight duty of candour letters we reviewed were not accurate, siting patient anatomy as a cause and not describing why two surgical procedures had been performed when one should have sufficed.
- The hospital should ensure theatre staff are informed about previous incidents and their investigation outcomes even if they are not present for the theatre team meeting.
- The hospital should ensure any communication between the general manager, hospital medical director (MD) and MDs is recorded.
- The hospital should ensure that the elevated room temperature in theatre three anaesthetic room is addressed to prevent a negative impact on patient care.