Horton Treatment Centre

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Horton Treatment Centre, operated by Ramsay Health Care UK, is an independent hospital based in Banbury. The hospital is located on the site of an NHS acute trust. The hospital has 40 registered beds, across 28 single or double rooms. Facilities include three operating theatres, a purpose built ambulatory care unit, physiotherapy, and outpatient and diagnostic facilities including a radiography department.

The hospital provides elective (planned) orthopaedic and spinal surgery, outpatients and diagnostic imaging. We inspected all of these services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 12 December 2016, along with an unannounced visit to the hospital on 19 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.

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.

Services we rate

We rated this hospital as good overall.

- Staff knew the process for reporting and investigating incidents using the hospitals reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Although the service used agency staff, wherever possible regular bank and agency staff were employed who were inducted and familiar with the service procedures. Medical staff practicing privileges were monitored to ensure doctors were suitable and safe to work in the service.
- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- Feedback from patients about their care and treatment were mostly positive. We observed patients were treated with kindness, compassion and dignity throughout our visit. We saw patient information leaflets explaining procedures and after care arrangements.

We found good practice in surgery:

- Staff completed comprehensive patient risk assessments from the initial pre-assessment clinic through to discharge. Care was provided in-line with national best practice guidelines and outcomes for patients were better than average. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.
- Patients had assessments of their needs and access to different methods of pain relief. Staff monitored and responded to patients' pain levels appropriately.
- The hospital treated 100% of NHS patients within 18 weeks of their referral from July 2015 to June 2016.

We found good practice in relation to outpatient and diagnostic services:

- There were efficient systems to keep patients safe and to allow staff to learn and improve from incidents.
- There was effective multi-disciplinary working with informative handovers, good record keeping and communication.
- The service was planned and delivered to meet people's individual needs.
- The leadership, governance and culture promoted the delivery of high quality person-centred care.

Summary of findings

We found areas of practice that require improvement in surgery:

- We were not assured that the World Health Organisation (WHO) five steps to safer surgery checklist was completed consistently with patients undergoing local anaesthetic procedures. This increased the potential risk of a patient safety incident occurring.
- In the theatre, the scrub area that facilitated two theatres was open to the main corridor. Staff were not aware this was not ideal as infection control standards could be compromised.

We found areas of practice that require improvement in outpatient and diagnostic services:

- Nursing staff had been applying plaster of Paris casts without formal competencies in place. There was no assurance that staff were competent to undertake this task.
- There was no evidence of an audit trail on the use of prescription pads.
- We were not assured that mandatory training completed elsewhere had been checked to ensure it covered the required elements.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and 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.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	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 caring, effective, responsive and well-led, although it required improvement for being safe.
Outpatients and diagnostic imaging	Good 	Outpatients and diagnostic imaging services was 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, effective, caring, responsive and well-led.

Summary of findings

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Services we looked at:
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Horton Treatment Centre

Horton Treatment Centre is operated by Ramsay Health Care UK Operations Limited. The hospital was purpose built in 2006 to provide elective orthopaedic services to NHS patients. It is a private hospital in Banbury, Oxfordshire. The hospital primarily serves the communities of Oxfordshire. It also accepts patient referrals from Buckinghamshire, Gloucestershire, Northamptonshire and South Warwickshire.

Horton Treatment Centre predominately provides orthopaedic and spinal NHS services. Other services include general surgery, cosmetic surgery, dermatology and pain management services to privately insured and self-funding patients.

The approximate breakdown of these specialties is as follows: orthopaedic 98.3%, spinal 1.1%, dermatology 0.4%, cosmetic 0.2%.

The hospital has had a registered manager in post since 2014.

Our inspection team

Our inspection team was led by:

Lisa Cook, CQC Inspection Manager.

The team comprised a CQC inspector, an assistant inspector and specialist advisors with expertise in surgery, outpatients and radiology.

Information about Horton Treatment Centre

The hospital had one ward, with twin and single rooms, all with en-suites. Facilities included three operating theatres, an outpatients department and diagnostic facilities. There was also a dedicated decontamination unit and a day case ambulatory care unit.

We inspected two core services at the hospital, which covered all the activity undertaken. These were surgery and outpatient and diagnostic services.

The hospital is registered to provide the following regulated activities:

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

During the inspection, we visited the ward, outpatients and diagnostics, physiotherapy and the operating department. We spoke with 29 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. During our inspection, we spoke with nine patients and we reviewed 15 sets of patient records.

There had been no special reviews or CQC investigations of the hospital during the 12 months prior to this inspection. The CQC has inspected the hospital four times, the most recent inspection took place in January 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- There were 2,990 inpatient, day case episodes of care recorded at the hospital; of these 97% were NHS-funded, and 3% other funded.
- 47% of all NHS-funded patients and 35% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 17,342 outpatient total attendances in the reporting period; of these 97% were other funded and 3% were NHS-funded.

Sixty-nine consultant surgeons, anaesthetists and radiologists worked at the hospital under practising privileges. Two regular resident medical officers (RMO)

Summary of this inspection

worked on a two week rota. The hospital employed 21.2 whole time equivalent (WTE) registered nurses, 16.1 (WTE) care assistants and 41.1(WTE) other hospital staff, as well as having its own bank staff.

The accountable officer for controlled drugs (CDs) was the matron Gina Taylor.

Track record on safety

There had been three never events July 2015 to June 2016:

- July 2015 related to a prosthesis mismatch, which consisted of a patient undergoing a hip replacement receiving a hip prosthesis head that matched the cup and not the stem.
- November 2015 related to a failure in the sharps count and consisted of a retained surgical blade in the patient's hip during a hip replacement.
- June 2016 related to a prosthesis mismatch, which consisted of a patient having the wrong size head fitted to the cup in a hip.

Clinical incidents 32 no harm, 49 low harm, 4 moderate harm, 0 severe harm, 1 death

No 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

22 complaints

Services accredited by a national body:

- Information Security Management System –ISO/IEC 27001:2013

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Laundry
- Maintenance of specialist medical equipment
- Pathology and histology
- Pharmacy services
- Specialist medical imaging
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- The infection control processes to the clean patient equipment were not robust. The equipment was visibly clean but it was not clear which items of equipment were ready for use. There was a risk that patients and staff could be using dirty equipment. On the unannounced inspection, we observed new infection control policies and procedures had been implemented.
- Scrub sinks in the operating department were outside of the operating theatre in the main corridor, a potential infection control risk.
- We observed an incident of a patient undergoing local anaesthetic procedures that indicated the WHO surgical checklist was not embedded into day-to-day practice.
- On the ward, fridges where medicines were stored were monitored. However, in theatres the temperatures were not being monitored and therefore there was no assurance that medication was stored correctly at all times.
- In the out patients department there was no clear audit trail for the use of prescription pads. Although action had been taken to implementa system when we conducted our unannounced visit.
- Although the hospital had met the mandatory training target for most modules, a number of staff had not completed acute illness management and intravenous training, which could pose a risk to patient safety.

However,

- There were processes in place for reporting incidents and staff confirmed they received feedback and shared learning. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- All clinical areas were visibly clean and staff had access to sufficient equipment to provide safe care and treatment.
- Patient records were accurate, stored safely and provided detailed records of care and treatment.
- Nurse staffing levels and skill mix were planned appropriately, implemented and reviewed. Medical staff practising privileges were monitored to ensure doctors were suitable and safe to work in the service.
- In general medicines were stored safely and staff administered medicines within the hospital's policy.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Staff provided care and treatment to patients following evidence-based guidance and standards.
- There was evidence of good multidisciplinary working within the hospital and out-of-hours services were provided when needed. Staff were positive about the 'daily huddles', where key updates were communicated.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- Nurses discussed pain relief with patients and provided information on the type of pain relief they could expect to receive as part of their procedure. Staff provided patients with information leaflets about their specific type of procedure.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.

Are services caring?

Good

We rated caring as good because:

- Feedback from patients about their care and treatment was positive and we observed staff being supportive and compassionate to patients. This included treating patients with dignity and respect, and in general maintaining privacy and confidentiality.
- Patients told us they felt they had sufficient information to allow them to be involved with their care and had their wishes respected and understood.
- Flexible visiting hours enabled patients to maintain supportive relationships with those close to them.
- Patients were contacted by the hospital after they had been discharged offering help and advice if required.

Are services responsive?

Good

We rated responsive as good because:

- The hospital and local clinical commissioning groups worked together to plan and deliver surgical services to meet the needs of local people.
- Admissions were pre-planned so staff could assess patient needs prior to treatment. This enabled staff to provide care to meet their specific needs, including cultural, language, mental or physical needs.

Summary of this inspection

- The hospital had strict selection criteria to ensure only patients whom the hospital had the facilities to care for were referred. Patients told us the whole process from booking their initial appointment, to being discharged post-surgery was efficient and well organised.
- The hospital achieved 100% of NHS patients treated within 18 weeks of referral from July 2015 to June 2016.
- The hospital dealt with the majority of complaints promptly, and there was evidence that the complaints were discussed amongst staff. Complaints were used to improve the quality of care. We saw that responses to complaints contained an apology and there was evidence that the concerns raised had been fully investigated.

Are services well-led?

Good

We rated well-led as good because:

- The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities.
- There was a clear leadership structure and staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- Staff said managers were available, visible, and approachable. Staff praised the leadership of the service and felt supported in their department. Staff spoke positively about the service they provided for patients and emphasised the importance of quality and the patient experience.
- Risk, quality and governance structures and systems, managed at departmental, hospital and corporate levels, were in place to share information and learning.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Requires improvement

The main service provided by Horton Treatment Centre was surgery. Where our findings for surgical services also apply to other services, for example, management arrangements, we do not repeat the information but cross-refer to this section of the report.

We rated safe as requires improvement because:

Incidents

- Staff reported incidents through the hospitals electronic reporting system. All staff we spoke with were aware of the electronic incident reporting system and told us they were encouraged to report incidents. Staff told us the system was simple to use and accessible to all.
- From July 2015 to June 2016, there were 86 clinical incidents reported in theatres and the ward. The majority (81) were graded as no or low harm with one case of an unexpected death. A patient died at home of natural causes after being discharged from the hospital following a surgical procedure. This was reported to the CQC.
- There had been three surgical never events in the reporting period (July 15 to June 16). Never events are a type of serious incident that are wholly preventable, where 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. Root cause analyses had been completed. The reports contained recommendations for learning and identified actions to prevent the incidents happening again, with agreed action plans.
- There were no regular mortality and morbidity meetings to discuss unexpected deaths or adverse incidents affecting patients. Staff told us such cases would be included in the clinical governance and medical advisory meetings as required.
- Learning from incidents was cascaded in team meetings at all levels from ward and theatre through to the Medical Advisory Committee (MAC) meetings. We reviewed minutes from the clinical effectiveness meeting and MAC meeting and found there to be shared learning throughout.
- 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 we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support. Staff gave examples of when they had applied duty of candour and learning because of an incident. The hospital made contact with a patient after a procedure had gone wrong. The patient received ongoing clinical support, a telephone call and a letter of apology. In this case, the patient was made aware when things had gone wrong and was provided with reasonable support.

Good

Surgery

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

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harm that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. The surgical ward participated in the NHS safety and medicine thermometer. Senior staff conducted monthly audits of patient falls, pressure ulcers, catheters and urinary tract infections. The audits showed that patients received predominantly 'harm free' care. However, information about the audits was not displayed.It is considered best practice to display the results of the safety thermometer audits; this allows staff, patients and their relatives to assess how the ward has performed.
- Staff routinely assessed patients for venous thromboembolism (VTE). The VTE screening rate was 100% from July 2015 to June 2016.
- The hospital had two incidents of hospital acquired VTE or pulmonary embolus (PE) during this period. A PE is a blockage of an artery in the lungs. The most common cause of the blockage is a blood clot.

Cleanliness, infection control and hygiene

- In the theatre, the scrub area that facilitated two theatres was open to the main corridor. Staff were not aware that this was not ideal as infection control standards could be compromise. The Health Building Note (HBN 26) Facilities for surgical procedures 2004 recommends scrub and gowning facilities are held in a dedicated room, with specific recommendations for size and layout. During the inspection, we observed beds stored in front of the scrub area, whilst patients were in the operating theatre.
- All clinical areas we visited on the ward were clean and tidy. We observed staff following good infection control practices, such as cleaning their hands before and after patient contact and ensuring they were 'bare below elbows', to minimise the risk and spread of infection to patients. However, they was no system to indicate theequipment was clean and ready to use. Staff were documenting cleaning of equipment in an infection control book, and we were not assured that equipment was clean for use. We informed management at the time of the inspection and on the unannounced inspection, we saw 'I am clean' stickers being used which were clearly visible, dated and signed appropriately.
- Staff had access to personal protective equipment such as gloves and aprons, which we observed them using appropriately. There were hand sanitiser points around the hospital for visitors to use, to reduce the spread of infection to patients. Patient rooms also contained washbasins.
- We observed domestic staff on the ward with cleaning trolleys using a colour-coded system to minimise the risk of cross infection.
- Clinical and domestic waste management was in line with guidance on the use of separate colours and receptacles. We observed staff handled contaminated waste and linen correctly.
- Clean linen was stored appropriately and readily available on the ward and in the operating department. The hospital used disposable curtains in all the treatment and consulting rooms. These where dated according to when they were put up and when they were due to be changed.
- There was an infection prevention and control (IPC) lead for the hospital and an IPC link for each department. The infection prevention control lead formed part of the clinical effectiveness committee, which met every three months. The committee prepared the yearly IPC programme of audits and teaching, ensuring any issues were raised with the board. We saw that the MRSA screening programme was discussed at the April and November 2016 meetings.
- Patient Led Assessments of the Care Environment (PLACE) for February 2016 to June 2016 showed the hospital scored 99% for cleanliness, higher than the England average of 98%.
- MRSA is a bacterium that can be present on the skin and can cause serious infection. There was a hospital policy that stated certain patients should be screened for MRSA prior to admission. This included orthopaedic patients, patients who had come from another hospital or patients who had a history of MRSA. Patients with a positive result received treatment prior to the hospital admitting them for surgery.

Good

Surgery

- Healthcare infection rates were low from July 2015 to June 2016. There were no incidences of hospital acquired MRSA, Clostridium difficile or Escherichia coli (E-Coli) across the hospital.
- Most staff had completed their mandatory training, records showed 95% of staff in theatres and 100% of staff on the ward had completed the infection prevention practical training. The hospitals target was 100%.
- Results from the most recent hand hygiene audit in December 2016 showed 100% compliance for staff on the ward and in the operating department. Staff completed annual hand hygiene mandatory training.
- The operating department was visibly clean, and there was a safe 'flow' from clean to dirty areas to minimise the risk of cross contamination of equipment. The hospital used single-use equipment where possible.
- Daily, weekly and monthly cleaning rotas were displayed in theatres. Staff were required to sign when cleaning had taken place. Senior staff monitored the completion of the cleaning tasks and the overall cleanliness of the department.
- In the operating theatres, we saw staff following the infection control policy. Information was clearly displayed above sinks to remind staff about correct handwashing procedures. We observed staff were bare below the elbows and were seen washing their hands and using hand sanitiser appropriately.
- All of the three operating theatres had higher levels of air filtration (laminar flow). This was particularly important for joint surgery to reduce the risk of infection.
- There had been 16 surgical site infections from July 2015 to June 2016. Senior staff had completed a root cause analysis for each infection, with the outcomes discussed at the clinical effectiveness meeting. There had not been any reoccurring themes between the causes of the infections. However, the rate of infections for primary hip arthroplasty and other orthopaedic and trauma procedures was above the rate of other independent acute hospitals we hold this type of data for.
- The hospital attended meetings with the local Clinical Commissioning Group Infection Control Committee who also monitored their compliance and infection rates.
- Within the hospital, there were decontamination facilities available on site, which decontaminated and sterilised surgical instruments. They had a defined cleaning pathway for surgical instruments after use. Decontamination of reusable medical devices was in line with national guidance.

Environment and equipment

- The ward and the operating department had portable resuscitation trolleys. The trolleys contained medication for use in the event of a cardiac arrest. Nursing staff checked resuscitation equipment either weekly or daily. The drawers of the resuscitation trolleys were checked every weekend. The top of the resuscitation trolley, including the defibrillator and oxygen cylinders, were checked every day. This was the case throughout the service and we saw evidence of this in documentation on top of the trolleys. The resuscitation trolleys all had tamper evident tags to alert staff to any potential removal of equipment.
- The clean utility room on the ward was accessible to the public and was not secure; this room contained needles and syringes, as well as chemicals. We raised this at the time of the inspection and at the unannounced inspection, the door had been made secure.
- All patient equipment we looked at had been checked for electrical safety appliance testing, stickers showed when the equipment was next due for service. Equipment checked included infusion pumps, blood pressure and cardiac monitors, as well as patient moving and handling equipment such as hoists.
- The onsite maintenance team would assist in fixing any broken or damaged equipment in a timely manner and staff told us how they would refer damaged equipment to the team.
- Staff could access the equipment they needed and said they had sufficient equipment to care for patients. There were hoists available. Staff we spoke with said they rarely used a hoist. Patients had access to physiotherapy equipment if required.

- Call bells were accessible for patients on the ward to enable them to call for assistance if required, including a cardiac alarm in case of a cardiac arrest.
- Sharps bins were available in clinical areas. These were labelled and emptied in accordance with the Royal College of Nursing Guidance to support the implementation of the Health and Safety regulations 2013 (sharps instruments in healthcare).
- Single use equipment such as syringes, needles, oxygen masks were readily available on the ward and in the operating theatre department.
- Access to theatres was restricted to swipe card access. This meant the area was secure and minimised the risk of unauthorised access. However, at the unannounced inspection we found a back staircase with unrestricted access to theatres from the physiotherapy department.
- Within the theatre, there was a four bedded recovery ward and an ambulatory day unit, which contained 10 cubicles. They were equipped with appropriate facilities to care for patients in the immediate post-operative period before they returned to the ward.
- All operating theatres had an adjoining anaesthetic room where patients were prepared for their operation.
- The decontamination unit on site provided sterile services for reusable medical devices and supplies. Surgical instruments were stored and transported through the departments safely.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements. All surgical instruments were electronically tracked. This meant that in event of a failure in the decontamination cycle/process or for infection control reasons they were traceable.
- Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if needed.
- Theatre staff kept registers of implants, for example hip and knee, to ensure details could be provided to the health care product regulator if required.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Staff completed a logbook for each anaesthetic machine to record the daily pre-session check.
- Theatres had a 'difficult intubation' tray that contained equipment for use when a patient's airway was difficult to manage. Staff completed a checklist to indicate that daily checks were made.
- The management of waste was appropriate with designated areas for segregation, storage and disposal of waste.
- The hospital maintained water supplies at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria colonisation.

Medicines

- There was a service level agreement (SLA) in place with an external pharmacy company. The pharmacist would visit the hospital three times a week (Monday, Wednesday and Friday) from 9am until 1pm. In each department, there was a communication book where nursing staff and the pharmacist could communicate messages if required. Staff on the wards told us they had good access to the pharmacist for advice and support.
- Pharmacist technicians visited the hospital twice a week. The ordering and delivery of medicines was planned for the time period when pharmacy personnel were at the hospital.
- Pharmacy and nursing staff monitored and managed stock levels of medicines and controlled drugs in line with the controlled drugs (Supervision of Management and Uses) regulations 2006.
- Controlled drugs (CDs), used for patients receiving post-surgical care on the wards and use in theatres, were kept in secure cupboards within locked rooms.CDs are prescription medicines that are subject to stricter legal controls under The Misuse of Drugs Act, 2001. We saw accurate records, which showed that CDs were routinely administered, and the CD stock was counted and checked by two nurses. We saw the hospital conducted a CD audit in September and December 2016 and they had achieved 100% compliance.

Good

Surgery

- Emergency medicines including oxygen were available for use and expiry dates checked regularly. There were piped medical gases on the ward and in the theatre. Portable oxygen cylinders were available for the transfer of patients from the theatre to the ward.
- Patients made staff aware of any allergies at their pre-assessment. Staff recorded this information on the front page of the care pathway so it was immediately visible, reducing the risk of harm to patients. Patients also wore a red wristband to make staff aware they had an allergy.
- We reviewed eight medication administration charts and found staff maintained them well, they were clear about the medications prescribed and medications for administration. The patients' prescription charts clearly documented any allergies.
- Medicines should be kept at the correct temperature to ensure their efficacy. We saw temperatures for fridges used to store medicines had been consistently and appropriately recorded on the wards. However, the temperatures were not monitored consistently in the operating department and we found medication that should not be stored in the fridges. The medication was removed at the time of the inspection. There was no assurance that medicines were stored at the correct temperature and fit for use.
- We found unlocked medication cupboards in the anaesthetic rooms. There was controlled access to the area but we questioned whether these risks had been considered. On the unannounced visit, we observed these cupboards were locked.
- There was an antimicrobial stewardship policy in place to assist in the administration of antibiotics. The policy provided guidelines in relation to antibiotic prescribing principles, dosages, antibiotic use and patient allergies.
- There was appropriately packaged and labelled medication available for patients to take home after their surgery. To Take Out (TTO) packs were stored in a specific locked cupboard in the clinical room.
- Patients told us nursing and medical staff had given clear instructions and advice about any medications they needed to use at home, prior to discharge from the ward.

Records

- There were two sets of notes kept for each patient, clinical records and nursing care records. Staff kept clinical records safe in a locked cabinet by the nurses' station. The hospital kept patients' care records in individual bedrooms assuring confidentiality. Staff did not raise any concerns about lack of availability of patient records.
- We reviewed eight sets of patient records. Records were in paper format and completed appropriately. Records were complete and contained details from admission through to discharge. All eight records we viewed were, legible, signed and dated.
- All of the care records included risk assessments appropriate to the type of operation and length of stay in hospital. For example, risk assessments for venous thromboembolism (VTE), pressure ulcers, malnutrition and a home environment assessment; this was particularly important for patients undergoing joint replacement surgery. All clinical risk assessments followed national guidance, for example, the use of a recognised score for the prevention of pressure ulcers.
- The clinical records included the World Health Organisation (WHO) five steps to safer surgery checklist. There were pages to complete with details of the patient's care during anaesthesia, surgery and recovery as well as their discharge arrangements. Records were comprehensive, complete, accurate and up to date.
- Patient records included multi-professional clinical notes, which included those from physiotherapists and occupational therapists, to support safe care and treatment.
- The hospital completed a rolling programme of patient record audits every month reviewing documentation of medical records, venous thromboembolism (VTE) deteriorating patient, nutrition and hydration. A senior member of staff reviewed ten sets of records and recorded compliance. In December 2016, the hospital scored 92% for the nutrition and hydration record audit. This showed fluid balance charts were not always completed in full. The actions from this audit were to provide further training at the next ward meeting.

- Theatre staff maintained a comprehensive log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register and in the patient notes.
- An operating theatre register was maintained, which was found to contain all the information needed to ensure that an accurate record was kept.

Safeguarding

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children.
- The hospital had a dedicated lead in safeguarding vulnerable adults and children and they were trained to Level 3. All staff knew who the safeguarding lead was and told us they would always approach them for guidance.
- There had been no safeguarding alerts or concerns from July 2015 to June 2016.
- Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.
- All staff had access to the provider's adult safeguarding policies and procedures via their intranet. Safeguarding resource folders were available on the ward; these included flow diagrams to assist staff in following the safeguarding process and help line numbers.
- Safeguarding training was part of staff mandatory training. All clinical of staff had to complete level one and two safeguarding children and young adults training. We found that 92% of staff had received safeguarding vulnerable adult's level two training and 98% had received safeguarding children and young adults level one training.
- Female Genital Mutilation (FGM) was part of mandatory safeguarding training. FGM is any procedure that injures the female genital organs for non-medical reasons.
- All staff had to complete Protecting people at risk of radicalisation (PREVENT) training every three years. Prevent training is the counter-terrorist programme which aimed to stop people being drawn into terrorist-related activity.

Mandatory training

- Mandatory training at the hospital included consent, fire safety, safer blood transfusions and infection control. Staff could access training on line and face-to-face training was available for basic life support, intermediate life support, manual handling and aseptic technique.
- The overall compliance rate for mandatory training provided by e-learning was 97% as of December 2016. There was some specific additional mandatory training for clinical staff. Information providedshowed variable compliance for both the operating department and ward in some of these areafor example illness management training (theatre 11%, ward 82%) and intravenous therapy (theatre 17% and ward 67%).
- The induction programme for new staff (including bank staff) covered all the key statutory and mandatory training.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but the medical advisory committee checked assurance of mandatory training. The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems.

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

- Patients' risks were assessed and monitored at surgical pre-assessment, and checked again before treatment. These included risks about mobility, cognitive understanding, medical history, skin damage and venous thromboembolism (VTE). Patients had to meet certain criteria before they were accepted for surgery, minimising risks to their health and wellbeing.
- Patients were required to complete a comprehensive preadmission questionnaire to assess if there were any health risks, which may be a contraindication to their surgery or require further investigations. Health

questionnaires were discussed with patients in the pre-assessment clinics. If a patient was identified as being at risk, referral was made by telephone or emailed to the anaesthetist responsible for the patient.

- Day case patients underwent the same pre-assessment key health questionnaire and risk assessments, reviewed on the day of surgery.
- The cosmetic surgeon carried out psychological screening for cosmetic surgery patients. The surgeon identified if the patient needed additional psychological assessment in advance of agreeing to surgery.
- Ward nurses met for a handover at the start of their shift to discuss all patients on the wards. Handovers were thorough and patient-centred and staff handed over changes in patient's conditions, which ensured that actions were taken to minimise any potential risk to patients.
- On the wards, patients with a known risk of falls were accommodated in rooms closest to the nurses' station, for close observation and to minimise risks of falls.
- Staff used the National Early Warning System (NEWS) to monitor patients and identify deterioration in their health. This is a series of observations that produce an overall score. An increase in the score would show a deterioration in a patient's condition. A plan was available in each patient record for staff to follow if their score increased.
- Staff took part in regular scenario-based training, including resuscitation simulation so staff could respond quickly and be rehearsed should a real life cardiac arrest occur. Feedback was given to individuals on their performance.
- All staff had access to a sepsis screening tool. Sepsis is a potentially life-threatening condition triggered by an infection or injury. We reviewed this tool, which provided clear directions of the actions to take if sepsis was suspected, including treatment and the need to escalate the patient to a senior clinician immediately, with transfer to the local NHS trust if required.
- In the event that a patient's condition deteriorated, a service level agreement was in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient, prior to the transfer to another hospital. From July 2015 to June 2016, there were eight patients who had an unplanned transfer to another hospital.
- A 'pre list brief' took place in theatres every morning prior to the list starting, this involved discussion for each planned procedure and for all staff in theatre on the day.
- The Five Steps to Surgical Safety Checklist (based on the WHO checklist) was used in the hospital. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning and end of each operating list and the World Health Organisation (WHO) surgical safety checklist, which included sign in, time out and sign out. We observed the five steps to safer surgery, including the WHO checklist, and found best practice was adhered to for patients who had a general anaesthetic. However, we did not see the same standard being used for patients that underwent procedures under local anaesthetic in theatres. For example, we observed one patient where checks were not completed prior to the anaesthetist's intervention. This was raised with senior management at the time.
- We reviewed eight sets of records all with fully completed safer surgery checklists. Staff audited the completion of the WHO checklist.The surgical safety checklist audits for November 2015 to November 2016 showed 100% compliance.
- A resident medical officer (RMO) was on site at all times. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for immediate response for example, in the case of a cardiac arrest or for non-urgent queries.
- Blood was stored safely and securely on the ward for use in an emergency, such as a significant patient bleed in theatre.

Nursing and support staffing

- Senior staff used a patient acuity and dependency tool to plan the required level of nurse staffing. Any unallocated hours were filled using bank or agency staff. Staffing levels were sufficient to support safe care. There was scope for the ward manager to adjust the tool's

predicted staffing requirement based on experience and professional judgment. Fewest clinical hours were required at weekends, when there was reduced activity, and staffing hours were highest midweek.

- We reviewed the rotas in theatres and found appropriate numbers and skill mix of staff, in line with Royal College of Surgeons guidelines and the Association for Perioperative Practice (AfPP). They were created three weeks in advance and reflected the expected caseloads in theatres.
- The night shift was always staffed with at least two registered nurses, this included when patient occupancy levels were low. This enabled staff to respond to emergency situations.
- There was a lower nurse to patient ratio for those patients requiring a higher level of care. The hospital had an on call registered nurse rota, which provided clinical cover out of hours.
- The hospital only undertook elective surgery. This meant the number of nursing and care staff needed on a particular day could be calculated and booked in advance.
- From November 2015 to October 2016, the hospital usage of agency nurses in the theatre department and on the ward ranged between 4% to 18%. Wherever possible the hospital used regular bank and agency staff.
- The resident medical officers stated they had a high level of confidence in the skills and experience of the nursing staff.

Medical staffing

- There were two consultant anaesthetists who were employed and 69 consultants with practising privileges at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within the independent sector. All medical staff had their status reviewed every five years by the hospital Medical Advisory Committee to check they continued to be suitable to work at the hospital.
- Consultants and anaesthetists were granted practising privileges if they met the hospitals criteria and were recommended by the medical advisory committee. We saw minutes of the meeting in February 2016 which granted two consultant anaesthetists full admitting rights and one surgeon specific admitting rights.
- Surgeons were responsible for their own patients and, in accordance with their practising privileges and Ramsay Health Care's Facility Rules surgeons, were expected to be available by telephone 24 hours a day if they had patients within the hospital and within a 30 minute commute to the hospital to attend if required. If they were not available, they had to provide suitable alternative surgical cover, ensuring all relevant staff at the hospital and their patients were aware of the cover arrangements.
- A member of the nursing staff told us that medical cover was good and consultants were always obtainable. They said they would return to see their patients if necessary and always provided cover arrangements when not accessible. There was an on call anaesthetist and a Registered Medical Officer (RMO) to provide support.
- Two RMOs worked in two week blocks and were based on site, available 24 hours a day, seven days a week. The roles of the RMOs were to review patients on a daily basis, prescribe additional medication and liaise with the consultants responsible for individual patients care.
- The RMO was very rarely disturbed overnight and when this occurred, it was noted and the hospital manager made aware to assess if other arrangements were required.
- We were informed that the handovers between RMOs were effective and thorough. This ensured that the RMOs had an understanding of the patients' needs on the ward.

Emergency awareness and training

- The hospital had local and corporate business continuity plans for use in events such as a power failure or adverse weather conditions.
- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Hospital-wide unannounced fire drills took place quarterly to test staff knowledge of the evacuation plan,

we were informed the last one conducted was out of hours. All staff completed annual fire safety training as part of their mandatory training and understood their responsibilities if there was a fire within the building.

Are surgery services effective?

Good

We rated effective as good because:

Evidence-based care and treatment

- Policies and guidelines were developed in-line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example, the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50.
- Venous thromboembolism (VTE) assessments were completed in accordance with NICE clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism)' for patients admitted to hospital.
- Pre-operative tests were taken in accordance with routine preoperative tests for elective surgery NICE clinical guideline 45 (2016).
- Patients' temperatures were measured and documented in accordance with inadvertent perioperative hypothermia, NICE clinical guideline 65.
- In line with professional guidance, the hospital had a process in place for the recording and management of medical device implants.
- There was an on-going audit programme to evaluate care and review clinical practice. The provider participated in the corporate national audit programme, which required hospital teams to audit different aspects of care provision on a monthly basis. We saw evidence this programme was adhered to and audit findings were presented at governance meetings. Recommendations for improvement were identified and actions to do this were put in place.
- The hospital told us that they benchmark their services against other Ramsay sites. The national clinical governance committee reviewed all key performance indicators.
- The hospital used a number of different care pathways depending on the type of surgery a patient was having, to ensure staff followed a set care pathway that met the needs of each patient.

Pain relief

- We saw pain relief was discussed pre-operatively, in theatre and on the ward. Post-operative pain was assessed by staff using a recognised one to ten scoring system (national early warning system) and action taken as needed. Whilst in recovery, pain levels were constantly monitored and the patient was only moved back to the ward when pain was under control. Recovery staff gave intravenous opiates titrated according to the patients pain score.
- Patients confirmed they were comfortable and pain relief was managed. All patients post-surgery told us they received pain relief as and when needed.
- Nurses within pre-assessment discussed pain relief with elective patients and provided them with an information leaflet on "managing your pain after your operation". This ensured patients knew of the type of medication available to them.
- The resident medical officer (RMO) could prescribe additional pain relieving medication or if there were significant concerns nursing staff would speak with the patient's consultant.
- The patient satisfaction inpatient survey in November 2016 showed 100% of patients surveyed stated that everything was done to help control their pain.

Nutrition and hydration

- Instructions about fasting times were given during the patients' pre-admission visit. Information included when they could have their last meal and how long they were able to drink water prior to their operation. The patients we spoke with confirmed they had received this information.
- We observed staff checking as part of pre-procedure checks when the patient had last eaten or drank and this was recorded in the patients care record.

- Patients had nutritional screening undertaken at pre-operative assessment or on admission. We saw Malnutrition Universal Screening Tool (MUST) assessments to assess nutritional risk were recorded in patient notes.
- Specific dietary needs were recorded on the hospital computer system, when patients were listed for admission. This enabled the catering team to be informed and provide suitable food for the patient during their stay.
- The housekeeper received a daily handover from the nurses. The handover identified patients who required special diets or those with food allergies. Menu options were available for patients who required special diets for religious or cultural reasons.
- Catering staff visited all patients identified as having specific dietary needs to ensure a full understanding of requirements.
- In the February to June 2016 Patient-Led Assessments of the Care Environment (PLACE), the hospital scored 92% for ward food, which was the same as the England average.

Patient outcomes

- Ramsay Health Care's national clinical performance committee reviewed the key performance indicators across the whole of the organisation and the hospital benchmarked itself against other Ramsay hospitals.
- The hospital submitted patient outcome data to a number of national audits, including the National Joint Registry, to enable it to monitor its performance and clinical outcomes against other services. The hospital also monitored outcomes such as transfers out, returns to theatres, infection rates and readmission rates.
- There were 10 cases of recorded unplanned readmissions to surgery within 28 days of discharge from July 2015 to June 2016. This is not high when compared to a group of independent acute hospitals, which submitted performance data to CQC.
- One patient had an unplanned return to theatre from July 2015 and June 2016. CQC assessed the proportion of unplanned returns to be 'similar to expected' compared to the other independent acute hospitals we hold this type of data for.
- Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement. PROMS measures the quality of care and health gain received from the patients perspective. From April 2014 to March 2015, data from PROMS showed the hospital was within the expected range for primary hip and knee replacement surgery.
- The hospital followed up patients one week after discharge by telephone, in the aid to highlight any concerns in a timely manner. The ward provided all patients with a contact number for the hospital prior to discharge.
- The hospital was part of the Public Health England (PHE) surgical site surveillance programme. The infection prevention and clinical outcomes nurse input the hospital's data into the PHE system. Staff carried out follow up patient telephone calls 30 days after major surgery.
- The hospital provided information to the Private Healthcare Information Network (PHIN) as legally required by the Competition Markets Authority (CMA).

Competent staff

- A senior nurse or manager was on duty each shift to provide expert advice and support for junior theatre staff and this was the case on the ward.
- All new staff underwent a corporate induction, which included a departmental orientation programme.
- Agency and bank nurses received orientation and induction to the ward and theatre. This included use of resuscitation equipment and medicines management.
- Ward and theatre staff confirmed that appraisals took place and staff told us they had received an annual appraisal. Records showed 90% of staff had had an appraisal in 2016, including administrative and clerical staff. We heard that the staff thought the appraisal system was effective as it formalised individual competencies achieved and identified training needs for the next year.
- Staff told us that there were link roles for nurses that included infection control, resuscitation and sepsis. Staff received protected time to attend training for these specific roles.

Good

Surgery

- Across the hospital, all health care assistants (HCAs) were undertaking or had completed the National Care Certificate. This is a set of standards that social care and health workers stick to in their daily working life.
- The chair of the medical advisory committee (MAC) and the general manager were responsible for granting and reviewing practising privileges for medical staff. This included evidence of; medical and surgical qualifications, specialist cosmetic surgery register registration, references, appraisal and revalidation data, their GMC number, and evidence of indemnity insurance. The chair of the MAC gave examples of when they had had withdrawn practising privileges, based on skills and competencies.
- For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their NHS employer together with the responsible officer's name.
- Any clinical practice concerns arising in relation to a consultant would be discussed at the Medical Advisory Committee meetings. Actions were created and completed before the consultant could practice at the hospital again.
- Surgeons who wished to bring first assistants to theatre had to speak to the MAC. The first assistant would have to provide a copy of their CV, immunisation status and evidence of their interest or experience. As part of practising privileges surgeons had to agree and sign that they would follow this process prior to bringing first assistants to the operating theatre. We saw from MAC minutes that the group had agreed to a first assistant as per Ramsay policy that all activity was consultant-led.
- Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) was completed. Data provided to us by the hospital showed a 100% completion rate of verification of registration for all staff groups working in inpatient departments and theatres.
- The Resident Medical Officers (RMOs) were employed through an agency and underwent an additional recruitment process before they commenced employment. This involved checking their suitability to work at the hospital and checks on their qualifications.
- Physiotherapy staff told us they had access to external training and they did not have any issues with access to financial support.

Multidisciplinary working

- The surgical service demonstrated multidisciplinary teamwork with informative handovers, good record keeping and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments and with the therapies planned.
- There was clear communication between staff from different teams, such as theatre staff to ward staff and between the ward staff and physiotherapists. We observed safe and effective handovers of care, between the ward, theatre and recovery staff.
- A hospital daily huddle took place every morning and each head of department attended and then fed back to their ward or department. When we spoke with staff they all told us they thought the daily huddle worked well and was used as a forum to discuss incidents, issues and staffing for that day.
- We observed a daily briefing, which was held each morning for all theatre staff to review the operating lists, provision of equipment, staffing for the day ahead. Fourteen members of staff attended including consultants and portering staff.
- Our review of records confirmed there were effective multidisciplinary working practices, which involved nurses, doctors, pharmacists, occupational therapists and physiotherapists. For example, we saw physiotherapists had followed therapy guidelines documented by consultants.
- There were service level agreements with the local NHS trust so patients could be transferred if they were unwell or required further intervention in a high dependency setting.

Seven-day services

- Planned operations took place Monday to Friday, each week from 8.30am to 6pm. The type of surgery was dependant on which consultant was booked in for which day. Staff were aware of the patient lists in advance to enable staffing levels and rooms to be available.

- Consultants were responsible for the care of their patients, from the pre-admission consultation until the conclusion of their episode of care.
- The RMO was on-call at all times and was based at the hospital, should staff need to escalate concerns about a patient. The RMO told us they were woken at night infrequently and therefore were normally able to rest between midnight and 7am.
- Theatre staff were on-call should there be any unplanned returns to theatre. Nursing cover was available on the wards, all day, every day, when the hospital was open. A member of senior management was available to support staff as part of an on-call rota.
- Physiotherapy staff supported effective recovery and rehabilitation by providing sessions to inpatients daily, including at weekends and an on-call service out of hours. Occupational therapist worked Monday to Fridays.
- The radiology department at the local NHS trust provided an on-call service outside of normal working hours and at weekends. Staff could contact the radiologists out of hours to authorise requests and review results in case of an emergency out of hours.
- The pharmacist was available by telephone during normal working hours, Monday to Friday.

Access to information

- Nursing, theatre and medical staff did not raise any concerns around access to patient records, they told us these were available when they admitted a patient for surgery.
- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment.
- Staff discussed with patients, their care in detail and explained what to expect post-operatively including length of stay, and involved patients in their plans for discharge. Ward staff gave patients a discharge pack with specific post-operative instructions.
- Staff told us they would refer patients identified as having a social care need to social services for an assessment.
- Discharge summaries were sent to GPs when patients were discharged from the hospital. Staff recorded this had been completed in the patient pathway document. Care and discharge summaries were also given to patients on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Surgeons gained consent from patients for surgery in the initial outpatients' appointment. Once admitted, on the day of the procedure the surgeon conducting the procedure recorded formal consent again.
- Relevant staff groups completed consent training as part of their mandatory training. As of December 2016, 88% of theatre staff and 80% of ward staff had completed this training. The hospital target was 100%
- A consent audit was conducted every three months. In December 2016, ten sets of notes were reviewed and found to be compliant in all areas. However, in four sets of notes there was no evidence that health care workers, who had completed the consent process, had received training in consent. The outcomes of the audit and actions to be taken were documented.
- Staff told us they very rarely saw patients who may lack capacity to make an informed decision about surgery. We spoke with staff about informed consent and they were clear about the procedures to follow for patients who lacked capacity.
- At pre-assessment, all patients over 75 years old were assessed using a six point cognitive assessment. Staff told us if they had any concerns about a patient's capacity, they would contact the RMO or consultant for support.
- Mental Capacity Act and Deprivation of Liberty Safeguards awareness training was included in Safeguarding training.
- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were clear. Unless otherwise requested, all patients who had a cardiac arrest were to be resuscitated. Staff advised us it was rare for a DNACPR form to be in place.

Good

Surgery

Are surgery services caring?

Good

We rated caring as good because:

Compassionate care

- All patients we spoke with were happy with the quality of care they had received. They told us staff had made them feel at ease and had felt comfortable and relaxed prior to having surgery. A patient told us 'staff are very kind and good'.
- We spoke to four patients whilst on inspection who all told us they were treated with dignity and respect at each stage of their stay in the hospital. They told us that staff spent time with them and put them at ease.
- Patients told us that staff were attentive and we observed that call bells were answered in a timely manner.
- Interactions we saw between staff and patients were compassionate, empathetic and respectful. Patients were positive about the care and treatment they received and one patient described the staff as "very caring".
- We saw patients' bed curtains were drawn and doors closed when staff cared for patients on the ward and in the theatre and recovery area. A light was used outside of each room when a member of staff was providing care to a patient. This was a further measure to maintain patient's privacy and dignity and to inform other staff that care was being carried out and they should not be disturbed.
- We observed staff took care to ensure patients' dignity was preserved. For example, they covered patients in the anaesthetic room, operating theatre and during transfers between the ward and theatre areas.
- We saw that staff knocked before going into bedrooms, waiting for a response prior to entering and therefore protecting patient dignity and privacy. Staff introduced themselves by name.
- We saw people treated as individuals and staff spoke to patients in a kind and sensitive manner. Staff were friendly, polite respectful and courteous.
- In the Patient-Led Assessments of the Care Environment (PLACE) privacy, dignity and well-being scored 85%, above the England average of 83% for the period between February 2016 and June 2016.
- In the reporting period (January to June 2016), the provider collected data for the friends and family test.The hospital had a response rate of 75% and achieved a score of 97% for NHS funded patients in the last month. Response rates were above the England average of NHS patients across the same period.
- Patient feedback was reviewed monthly and scores and comments shared and reviewed at the clinical governance meeting and shared with relevant clinical commissioning groups.

Understanding and involvement of patients and those close to them

- Information was given to patients about their procedures at their pre-admission appointments. All of the patients we spoke with told us they felt they had been given sufficient information pre-operatively to prepare them for the procedure and their post-operative requirements.
- Patients told us all staff had given clear explanations, in sufficient detail for each stage of their care and treatment, from initial consultation through to discharge.
- Patients valued seeing the physiotherapist during the pre-operative assessment, so they understood the exercise programme they needed to complete after their surgery.
- Patients on the wards said they understood their care and treatment and had adequate opportunities to discuss their surgery. Patients said, "Staff explained everything that was going to happen at each stage".
- The hospital's patient satisfaction survey, for the period between September 2016 and November 2016 showed 100% of patients said they were involved in decisions about their care and treatment.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.

Emotional support

Good

Surgery

- Patients were positive about the emotional support they received from staff especially around anxiety pre and post-surgery. We saw that staff were empathetic towards patients and spent time alleviating patients concerns and anxieties.
- Sufficient time was allocated for the pre assessment appointment to allow patients time to discuss any fears or anxieties.
- Ward staff demonstrated sensitivity towards the emotional needs of patients and their relatives.
- There was open visiting on the ward to allow patients to have emotional support from family and friends.
- Bereavement and chaplaincy services were provided via the existing service level agreement (SLA) in place with the local NHS Trust.
- Patients were able to telephone the ward after discharge, for further help and advice on their return home.

Are surgery services responsive?

Good

We rated responsive as good because:

Service planning and delivery to meet the needs of local people

- The hospital worked with the local Clinical Commissioning Group (CCG) to plan services for NHS patients. Patients selected the hospital through NHS e-Referral Service or were referred from the local musculoskeletal service.
- The hospital provided elective surgery to NHS and private patients for a variety of specialities, which included orthopaedics, spinal, general and cosmetic surgery.
- The service admission criteria ensured only patients for whom the hospital had facilities to care for were referred. Patients admitted had a low risk of complication and their post-surgical needs could be met through ward-based nursing care.
- All admissions were pre-planned so staff could assess patients' needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, including cultural, linguistic, mental or physical needs.
- Patients had an initial consultation to determine whether they needed surgery, followed by a pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this.
- The provider had plans to further develop the ambulatory care service at the hospital for patients who did not require a full ward admission. An ambulatory care service allows patients to be treated in hospital without the need for an overnight stay. It ensures patients receive timely access to treatment and releases inpatient beds for those who require an overnight stay.

Access and flow

- The operating department was open from 8.30am to 6pm Monday to Friday. Occasionally it opened on a Saturday to run extra operating lists depending on demand. This meant there was a planned programme of activity.
- From July 2015 to June 2016, 100% of patients were admitted for treatment within 18 weeks of referral. The national target was 92%.
- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- Dates for surgery were discussed with patients at their initial outpatients' appointment. Patients were able to choose to have their operations at times suitable for them.
- All of the patients we spoke with told us they had short waits for their surgery.
- There had been three surgical operations cancelled on the day from July 2015 to June 2016, for non-clinical reasons, for example staffing issues.

- The staff in the operating theatres provided an on-call service to ensure that the department could be opened if there was a need for a patient to return to theatre urgently.
- Staff communicated planned changes to the surgical lists effectively. For example, they had implemented a different coloured sheet for changes to the order of theatre list on the day. However, on the unannounced inspection, there had been a change of order to the theatre list and there were difficulties in altering the list on the computer system.
- Discharge planning started at the pre-assessment stage. The hospital considered support such as care at home and staff made contact with families or outside agencies such as social care.
- Discharges were authorised by the patient's consultant. On occasions, the resident medical officer (RMO) would discharge the patient with the consultant's instructions. Patients could be discharged in a timely manner.

Meeting people's individual needs

- Pre-assessment was used effectively to ensure the hospital only treated patients if they could meet their needs. The pre-assessment nurse confirmed that all patients were pre-assessed for surgery in advance. If the nurse identified any concerns, they had good communication links with the surgeons for advice and discussion.
- During the patient's pre-assessment visit, nursing staff gave patients information leaflets about their planned procedure or treatment during their appointment. The pre-assessment nurse also asked patients if they needed an interpreter for their stay in hospital.
- We found that the service did not treat complex patients or those with multiple co-morbidity due to not having a level two care facility (High Dependency Unit).
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2016 showed the hospital scored 96% for a dementia friendly environment, which was higher than the England average of 80%.
- The layout of the hospital meant that all areas were accessible for people using a wheelchair or walking aids. The hospital had lift access to each floor and wide access for wheelchairs.
- For patients' with visual or hearing loss, signage was available and a hearing loop was provided in the hospital.
- For patients whose first language was not English, telephone translation facilities were available. Some leaflets were available in a choice of languages as well as braille or audio cassette, for example, the NHS inpatient pre admission information booklet.
- We were told that should a patient require the support of a carer or a family member they would be encouraged to stay at the hospital to offer familiar assurances and to assist with the rehabilitation process. Larger single patient bedrooms were available for relatives to stay with patients if they wished.
- There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.
- Family and friends could visit patients on the ward at any reasonable time.
- Call bells were accessible for patients on the ward to allow them to call for assistance if needed.
- We saw a patient and relative lounge area on the ward. A nurse we spoke with told us that patients were encouraged to use this area to engage with family and friends. We noted that the environment was peaceful, with access to drinking water and reading material.
- Patients had access to physiotherapists and occupational therapists if needed. However, due to funding, NHS patients were limited to four physiotherapy sessions post discharge.
- Patients who were going to have a hip or knee operation were offered pre-operative physiotherapy sessions, which offered patients a chance to ask questions about their procedure.

Learning from complaints and concerns

- The hospital had an up to date complaints policy with a clear process to investigate, report and learn from a complaint. There had been 23 complaints for the period January to September 2016.
- The hospital director and matron monitored all complaints and responded to them in-line with the hospitals policy. The policy stated that complaints

would be acknowledged within two working days and a full response in 20 working days. Complaints were investigated by the relevant head of department with involvement from consultants and nurses if needed.

- There were procedures for sharing and learning from complaints across the hospital. Complaints were discussed at the Medical Advisory Committee (MAC), clinical governance meeting, the heads of department meeting and at the daily communication meeting. Lessons learned were cascaded down the organisation through departmental meetings. Ward meeting minutes showed evidence of staff discussing complaints and implementing change. For example, at the July 2016 ward team meeting staff were reminded that pain control must be a high priority and pain relief given in a timely manner, following a complaint about pain management.
- NHS patient complaints were discussed at the contract review meeting with the local Clinical Commissioning Group (CCG).
- Patients had access to guidance about how to make a complaint throughout the hospital.
- All of the patients we spoke with told us they had no complaints about the care and treatment they had received at the hospital.

Are surgery services well-led?

Good

We rated well-led as good because:

Leadership

- The general manager had overall accountability for the hospital. The matron, support services manager and finance manager took responsibility for their respective areas at the hospital. All the heads of department reported to one of these four people.
- There was a clear leadership structure in place and staff felt supported by management. All staff told us the senior management team were highly visible. Staff described knowing them on first name terms and were encouraged to give feedback.
- We observed staff demonstrated mutual respect. There was effective teamwork and professionalism in the way the organisation was managed.
- The hospital was aware of, and had systems in place to ensure, compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- All staff we spoke with were positive about working for the service, they felt listened to and valued. They said patients and staff knew if they raised an issue, it would be taken seriously.
- The resident medical officers (RMOs) were positive about the culture and commented that all staff worked well together.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.

Vision and strategy for this this core service

- The Ramsay Health Care corporate vision and strategy values for 2016 to 2017 focussed on patient care, cost effectiveness, engagement with stakeholders, valuing staff, delivering quality care and multidisciplinary working. Senior staff we spoke with told us of a commitment to the value of 'The Ramsay Way' delivering high quality care.
- There was a hospital business plan in place to support the achievement of the corporate vision. This included aims and objectives, and any challenges to achieving the aims, particularly the financial impact.
- At a local level, the vision of the hospital was communicated through the clinical nursing strategy and hospital strategic business plan, underpinned by the 6 C's. The '6Cs' help staff to focus on six key areas; care, compassion, competence, communication, courage and commitment. It was also based on a strategy of constant improvement through governance, training and safe staffing.
- All staff we spoke with were aware of the hospital wide values and were able to describe them to us, which included high standards of care, a positive working environment and staff development.

- Staff demonstrated the hospital values and behaviours in the care they delivered. All staff we spoke with were passionate about the service they provided and believed they consistently put the patient first.

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

- There was a clear governance structure in place with committees such as the clinical governance, health and safety, heads of department, clinical effectiveness and the medical advisory committee feeding into the senior management team.
- The clinical effectiveness committee was led by the matron and consisted of the quality improvement, resuscitation, blood transfusion, safeguarding, child safeguarding, medicines management, infection control and occupational health leads.
- The clinical effectiveness committee set six monthly clinical objectives. We reviewed the clinical objectives for August to October 2016, which incorporated specific ward, theatre, radiology, physiotherapy, and outpatient department objectives. For example, one objective was to analyse patient falls and take steps to educate patients to prevent harm.
- The clinical governance committee (CGC) met every three months. The minutes from meetings held between November 2015 to August 2016 showed discussions around core topics such as complaints, the risk register and incidents.
- The medical advisory committee (MAC) had a role in granting, reviewing and renewing consultants practising privileges.MAC meetings were held every three months, we reviewed the minutes of those meetings which showed they discussed complaints, hospital activity and practising privileges.
- There was one hospital wide risk register. The register detailed 17 risks, which were identified as a potential risk to the whole hospital. These risks included; termination of lease, staffing, risk of infection and risk of the failure of equipment. The risk register showed the nature and level of a risk, the control measures required and the name of the staff member responsible for control of the risk.
- The hospital had local risk registers for each department, which were regularly reviewed and updated to ensure risks were monitored and appropriately managed. Managers within theatre and the wards were aware of the specific risks to their areas of work.
- Team meetings were held regularly on the ward and theatres. These were used for the passing of two-way information.
- Staff told us they found the daily 'huddle' a useful way of communicating information across the hospital. Senior staff and heads of department discussed daily activity, incidents and theatre schedules.

Public and staff engagement

- The patient satisfaction survey was undertaken by an external organisation. Patients gave consent to be contacted by telephone or email. The hospital used this with the 'Friends and Family test' feedback to evaluate the service provided to the patient. The volume of the call bells were decreased and patients were offered ear plugs, following patient feedback.
- The Ramsay employee survey was completed in 2016, incorporating the whole of the organisation. The employee engagement group was introduced following the 2016 Staff Survey.
- We saw minutes from the employee engagement group, which discussed various topics including social events organised by the hospital, hospital updates, staff satisfaction surveys and fundraising. A member of the senior management team chaired the meeting.
- There was an organisation newsletter, which was distributed throughout the hospital to update staff on current issues and plans.
- Staff we spoke with said they felt involved and included. Ward meetings were a good source of information where minutes were made available if they were unable to attend.

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

- The senior management had long-term plans to develop the service to increase the number of referrals and develop their ambulatory care service to reduce the need for patients to stay overnight.

Good

Surgery

- The care certificate had been introduced for all healthcare assistants.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

Incidents

- The hospital had an incident reporting policy, providing definitions of incidents, never events and near misses. Heads of departments reviewed incident reports, instigated investigations and escalated any risks to senior management.
- Staff we spoke with understood the incident reporting policy and knew how to report incidents.Staff were aware of the types of incidents that they needed to escalate and told us they were encouraged to report incidents. All staff employed by Ramsay Health Care UK had access to the hospital's electronic reporting system. Radiographers working at the hospital under a service level agreement did not have access to the reporting system. Incidents were escalated to the Radiology Manager who could report the incident on their behalf. Staff assured us that this process worked effectively.
- There were no clinical incidents in outpatients or diagnostic imaging in the reporting period (July 2015 to June 2016). Within the same reporting period there were two non-clinical incidents reported by outpatients or diagnostic department staff. This number was not high when compared to a group of independent acute hospitals that submitted performance data to CQC.
- Due to the way in which incidents were collated, isolated physiotherapy incidents could not be separated from those that occurred on the ward. We were told by the physiotherapy manager that patient falls were the most common physiotherapy incidents reported.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000, IR (ME) R. There were clear processes for reporting IR (ME) R incidents; they were to be reported on both the hospital's reporting system and the local NHS incident reporting system. There were no reported radiation incidents in the last 12 months.
- From July 2015 to June 2016, there had been three reported never events, none of which occurred in the outpatient or diagnostic imaging department. Never events are a type of serious incident that are wholly preventable, where 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 occurrence of a never event could indicate unsafe practice.
- There was evidence of positive improvements and changes made as a result of incidents. Incidents were discussed at senior management meetings, clinical governance meetings and locally at team meetings. Learning was identified from investigations and this was disseminated and shared with staff within the outpatients, diagnostic and physiotherapy departments. For example, staff discussed manual handling training in the September 2016 outpatients team meeting, following an incident where a member of staff was injured.

Good

Outpatients and diagnostic imaging

- From July 2015 to June 2016, the service reported no patient deaths relating to care and treatment. The Horton Treatment Centre did not host mortality or morbidity meetings. Consultant anaesthetists attended the local NHS hospital's mortality and morbidity meetings.
- The duty of candour (DoC) 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 were aware of the principles of DoC and could give examples of when DoC would be triggered.

Cleanliness, infection control and hygiene

- All areas of the outpatient and imaging department, including the consulting and treatment rooms, waiting areas, and gymnasium, were visibly clean, tidy and free from clutter. Signed cleaning schedules were in place and housekeeping staff cleaned the departments daily.
- We observed staff to be complying with best practice with regard to infection prevention and control policies. All staff participated in infection control training as part of their annual mandatory training. As of December 2016, 100% of outpatients, radiology, physiotherapy and administration staff had completed their annual infection control training (hospital target 100%).
- Hand sanitiser points were widely available throughout the department, including within the waiting areas, to encourage good hand hygiene practice. We saw staff following 'bare below the elbow' guidance, with the exception of some consultants, although hand hygiene audits did not reflect this finding.
- Infection control practices were monitored by the infection prevention and control (IPC) lead. There was also an IPC link for the outpatients department. Staff conducted regular infection control audits, and produced an annual infection control action plan. The most recent hand hygiene audit showed 100% compliance (December 2016).
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas to ensure their safety and reduce the risk of cross infection when performing procedures. We saw staff used PPE appropriately.
- Equipment was labelled with 'I am clean' stickers to indicate it was ready for use.
- Domestic and clinical waste was disposed of correctly. We saw appropriate facilities for disposal of clinical waste and sharps (such as needles) located in the consultation and treatment rooms. The hospital had different coloured bins to clearly identify categories of waste. This allowed staff to safely handle biological or hazardous waste and was in accordance with current legislation.
- The hospital also had different coloured laundry bags to categorise non-infected (white bag) and infected linen (red bag).
- All infection cases were reported on the electronic reporting system. The hospital reported no cases of MRSA, Methicillin Sensitive Staphylococcus Aureus (MSSA), Clostridium difficile (C. diff) or Escherichia coli (E-Coli) infections within the reporting period (July 2015 to June 2016).
- The hospital followed a risk-based approach to MRSA screening. Staff screened all patients deemed to be a potential infection risk at pre-admission.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. The hospital scored 99% for cleanliness, slightly above the England average of 98%.

Environment and equipment

- The outpatients and diagnostic imaging departments were well-maintained. Consulting rooms were well equipped and provided a suitable environment for treating patients. The outpatients department had a treatment room for patient dressings and the removal of sutures and clips.
- There were systems in place for equipment servicing, testing and maintenance. Staff labelled equipment to record the last service date and review date. Staff reported faulty equipment using a maintenance request form. There was an on-call engineer available to manage emergency equipment failures or facility concerns. Staff told us the maintenance process was efficient as equipment needs were prioritised.

Good

Outpatients and diagnostic imaging

- Staff did not report any concerns regarding availability or access to equipment. Equipment procurement requests were made via heads of department.
- Staff had access to emergency equipment including oxygen cylinders, defibrillators and resuscitation equipment. The outpatients and radiology department had a resuscitation trolley for staff use in the event of a cardiac arrest. Staff followed the Resuscitation Council (UK) guidelines displayed on trolleys. Each trolley had tamper evident tags to alert staff if the trolley had been opened. Staff carried out daily and monthly checks to ensure the trolleys held all the necessary emergency equipment.
- Single use, sterile instruments were used where possible and those we inspected were within their expiry dates.
- Disposable curtains and wipeable chairs were used through the outpatients and radiology departments. Disposable curtains were dated according to when they were put up and when they were due to be changed.
- Equipment for bariatricpatients was not needed as the hospital's admission criteria restricted bariatric patients from being referred for treatment.
- The radiology department had appropriate signage and warning lights outside each imaging room to alert staff and patients when exposures were undertaken. Access to store rooms was secure via a coded key pad system. Visual and detailed checks of lead aprons were carried out, and results were logged.
- A radiation protection advisor (RPA) from the local NHS trust undertook radiation safety audits against the Ionising Radiation (medical exposure) Regulations IR (ME) R. An audit completed June 2015, identified no major non-compliances, however some recommendations were made to standardise practice. All recommendations had been acted upon in a timely manner.
- The Radiology Manager was responsible for maintaining an up-to-date inventory of radiation equipment, with support from the Medical Physics Expert.Radiology equipment was serviced by the manufacturers, who would also attend if a fault was reported.

Medicines

- Medicines were stored safely. In the outpatients department staff stored all medicines in a locked cupboard, in a secure clinical room. Only nurses had access to the locked cupboard. Fridge temperatures were checked daily and logged to ensure medicines were stored at the correct temperature. We checked eight medicines which were all in-date.
- We found prescription pads were stored safely in a locked cupboard but there was no evidence of an audit trail on the use of prescription pads. There were no accurate records to show when staff used prescription pads to prescribe medication and we found prescription forms to be missing from the pad.
- We raised our concerns with the outpatients' manager who was proactive and had begun to address our concerns when we returned to the hospital for an unannounced visit. Two standard operating procedures (SOPs) had been created since our first inspection visit. One for the management of the private prescription pads stock level, and one for the recording of a private prescription written for a patient. The SOPs described how stock level would now be monitored using a private prescription traceability register.
- Radiology contrast media were stored in a locked drugs cupboard, in a locked clean store room. Codes were changed every six months to maintain security. The room temperature was monitored and logged to ensure these items were stored at the correct temperature. All medicines in the drug cupboard were checked and in-date.
- At the time of our inspection, all flammable medicines were stored in a yellow flammable cupboard in outpatients. The imaging department had ordered a flammable cupboard so that they could store flammable medicines in their own department. This had arrived on our unannounced visit.
- There was no pharmacy on site. The hospital had a service level agreement with an external pharmacy company to visit the department three times a week. Staff reported good access to the pharmacist for advice and support.
- For our detailed findings on medicines please see the safe section in the surgery report.

Records

Good

Outpatients and diagnostic imaging

- The hospital had a medical records management policy, which set out responsibilities for all staff members in the creation, handling, storage and destruction of records. It also detailed standards for confidentiality and set out rights to access records.
- Medical records were available for all patients who attended an appointment and we saw no evidence that patients were seen without adequate clinical information.
- Medical records contained important information such as test results, patient risk factors, past medical history and emergency contact details. All records were in paper format.
- Records were stored securely in locked trolleys. As part of our inspection, we reviewed the records of seven patients; we found them to be accurate, complete and up to date.
- The medical records department prepared patient records several days in advance of a patient's appointment. Staff took the records to the outpatients department the day prior to consultation in locked trolleys.
- The Medical Records Clerk ensured all patient information was present in the patient record. The administrator ensured all appropriate documentation was complete before the appointment took place and asked new patients to complete a medical questionnaire.
- Staff did not take records off site except for when they were required for an outreach clinic. In that case the records were prepared in the same way and transported in a secure, robust bag marked private and confidential.
- The hospital's annual audit programme included the review of medical record documentation. The last audit, in July 2016, showed good management of records (99% compliance achieved).
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to store clinical patient images. This system was available locally and used across the imaging department. It was also used to share patient images with other Ramsay Health Care UK hospitals.

Safeguarding

- The hospital had safeguarding systems and processes in place to ensure that people were kept safe. Staff followed a 'safeguarding adults at risk of abuse or neglect' policy, based on national guidelines from professional bodies and the Department of Health. Safeguarding flow charts were available in all departments to outline the process to follow should staff have safeguarding concerns.
- The hospital closed their adolescent service in November 2016. Despite this, all staff received mandatory training for safeguarding adults and children, as children often accompanied adult patients at their appointments.
- Safeguarding training was part of staff mandatory training. As of December 2016, 92% of staff had received safeguarding vulnerable adult's level two training and 98% had received safeguarding children and young adults level one training. Safeguarding training included information on Female Genital Mutilation and Child Sexual Exploitation.
- The outpatient manager had recently become the safeguarding lead, supported by Matron. The safeguarding lead had received level 3 adult and children safeguarding training and demonstrated a clear understanding of their safeguarding responsibilities. However, we were not assured that the safeguarding lead would be alerted to all safeguarding referrals made within the hospital.
- There were no safeguarding concerns reported to CQC in the reporting period (July 2015 to June 2016).
- Staff followed an adapted World Health Organisation (WHO) safety checklist 'Five steps to Safer Surgery' to ensure the right patient received the correct radiological investigation at the right time.

Mandatory training

- The hospital had a mandatory training policy that applied to all staff employed by Ramsay Health Care UK, including independent consultants and those employed as sub-contractors. According to the policy, if a sub-contracted staff member could provide evidence that they had completed equivalent mandatory training elsewhere; this alternative may be acceptable at the manager's discretion. This avoided staff duplicating training.

Good

Outpatients and diagnostic imaging

- All radiographers completed their mandatory training with the local NHS trust. The Radiology manager checked this was completed for all radiographers in the department. We were not assured that the senior management team had assessed the content of this training against the mandatory training set by Ramsay Health Care UK.
- Staff completed a number of mandatory training modules as part of their induction and updated them in line with the current training policy. Mandatory training included data protection, infection control, manual handling and workplace diversity. As of December 2016, 97% of e-training was up-to-date. Training was mostly delivered through an online learning package but there were also practical training days for staff to complete face to face training.
- The hospital's mandatory training matrix was used to determine staff training requirements, dependent on their role. For example, only clinical staff required training in blood-borne viruses.
- Department managers monitored training and would notify staff when their training was due for renewal. Staff were positive about the training their received and were confident they would be supported to attend additional training if requested.

Nursing staffing

- The hospital used an electronic rostering system to plan and review staffing levels on a daily basis. The system enabled heads of departments to manage rotas, shift allocations, annual leave, sickness, skill mix and staff requirements, including senior cover.
- Staffing rotas within outpatient departments were planned on a nurse to health care assistant ratio of 1 to 1.1. From July 2015 to June 2016, the department had 1.4 full-time equivalent registered nursing staff and 1.6 full-time equivalent health care assistants.
- The use of bank nurses in outpatients was high, when compared to other independent acute hospitals (July 2015 to June 2016). However, this high use was a planned way of managing the department, allowing for flexible working.
- The use of bank health care assistants was low, when compared to other independent acute hospitals (July 2015 to June 2016).
- Agency nursing staff were not used within outpatients and there were no nursing vacancies at the time of our inspection.

Allied Healthcare Professional staffing

- The physiotherapy department had 10 staff in total; four physiotherapists, one physiotherapist assistant and five bank physiotherapists.
- The radiology department was staffed by a full time radiology manager, a rotation of radiographers employed by the local NHS hospital, and a health care assistant.
- A team of administrators and medical secretaries supported outpatients by organising appointments, clinic management, typing up notes, and covering reception.

Medical staffing

- A resident medical officer (RMO) was on site 24 hours a day, seven days a week. If required the RMO attended the outpatients and radiology departments to provide advice and assistance.
- From 1 April 2016, the hospital employed 69 consultant medical staff working under practising privileges. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within the independent sector. Practising privileges were granted following a thorough review by the local Medical Advisory Committee who advise on the suitability of candidates and make recommendations.
- At the time of our inspection, radiologists were employed under a service level agreement with the local NHS hospital. We were told by the radiology lead that this employment was to be amended so that radiologists were also working under practising privileges.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital outpatient and administration teams.
- Consultants maintained responsibility for their own patients for subsequent follow up appointments such as post-operative dressings and were responsible for arranging cover if absent.

Good

Outpatients and diagnostic imaging

Emergency awareness and training

- There were business continuity plans for the outpatient and radiology departments. These included contingency plans for use in the event of a radiation incident or flood.
- The service had back-up generators in the event of a power failure. Maintenance checked these on a monthly basis.
- For our detailed findings on emergency awareness and training please see the safe section in the surgery report.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective as we do not currently collate sufficient evidence to rate this.

Evidence-based care and treatment

- Staff in the outpatient and diagnostic imaging departments delivered care and treatment in line with evidence-based practice. Corporate policies and procedures followed recognisable and approved guidelines such as National Institute for Health and Care Excellence (NICE) guidance. The policies we reviewed were all up to date and had clear dates for review.
- Updated clinical guidance was reviewed at national level, and fed back to staff through the hospital's clinical governance and medical advisory committees.
- We saw the local annual audit programme, this included audits reviewing medical records, preadmission/ discharge, consent, controlled drugs, and infection prevention and control.
- There were radiology specific audits, which evidenced compliance with IR (ME) R and best guidelines. Radiology audits included referral form completion and audits of magnetic resonance imaging (MRI) scans. Staff undertook audits of diagnostic reference levels (DRLs) to ensure patients were being exposed to the correct amount of radiation for an effective, but safe image for each area of the body. We reviewed a pelvis dose audit (April 2016) and found that patient doses were well within acceptable levels.
- Physiotherapy specific audits encompassed the Chartered Society of Physiotherapy (2012) Quality Assurance Standards Audit Tool.
- The staff in the outpatients' department were looking to develop their own outpatient audit programme to complete alongside the annual audit programme. Audit results were discussed at clinical governance meetings and locally at team meetings.
- New NICE guidelines were sent to the hospital quarterly, following corporate review. Matron reviewed NICE guidelines applicable to the Horton Treatment Centre and they were then discussed at clinical governance and clinical effectiveness meetings. We saw that new policies were disseminated to staff to read, sign and implement.
- Standard operating procedures (SOPs) were available for a range of procedures for example the management of specimen results and the process for patients who do not attend their appointments.

Pain relief

- Staff in the outpatient department discussed pain and options for pain relief with the patients during consultations. Staff provided patients with an information leaflet on managing pain, ensuring all patients were aware of the type of medication available to them post-procedure.
- The outpatients department had a pain management lead who could offer advice and training to colleagues.
- Patients who attended the imaging department received a pain diary upon discharge.
- Following a formal complaint in January 2016, all nursing staff received additional pain management training.

Patient outcomes

- There were 12,511 patient attendances in the outpatient department from July 2015 to June 2016; of these, 97% were NHS funded patients and 3% were funded through insurance or self-paying patients.
- The hospital submitted patient outcome data to a number of national audits, including the Patient

Reported Outcome Measures (PROMs) and National Commissioning for Quality and Innovation (CQUINs) This enabled the hospital to monitor its performance and clinical outcomes against other services.

- The hospital participated in local audits following the Ramsay National Audit Programme. This programme identified audits for the hospital to complete throughout the year to monitor different aspects of care provision on a monthly basis. The audits identified weakness within the service so that change could be implemented via action plans.
- Physiotherapists monitored patient outcomes in physiotherapy on an individual level by well recognised outcome measures such as range of movement, pain scores and quality of life measures. This established effectiveness of treatment and allowed for functionality comparison pre and post treatment.
- The hospital also monitored outcomes such as transfers out, returns to theatres, infection rates and readmission rates. For our detailed findings on patient outcomes please see the effective section in the surgery report.

Competent staff

- All new staff underwent a corporate induction, which included a departmental orientation programme.
- Within each department, staff had specific competencies to achieve, which were monitored by the heads of department. For example, within outpatients, staff were required to complete a competency in the assessment, management and administration of post-operative pain relief.
- During our inspection, we found nursing staff within the outpatients department had been applying plaster of Paris casts without formal competencies in place. There was no assurance that staff were competent to undertake this task.
- All healthcare assistants were undertaking the National Care Certificate.
- Each staff member had an annual appraisal of performance. This was used to determine strengths, weaknesses, and areas for improvement and development. Following the results of the staff survey, managers had agreed to focus on career development within staff appraisals.
- All outpatient nurses had had their appraisals completed in 2016 by the outpatient manager. The health care assistants working in outpatients, radiology and physiotherapy had also received appraisals within the previous year (2016).
- The imaging and diagnostic team had a comprehensive induction checklist, and we saw evidence that competencies were checked for individual staff.
- The physiotherapy department had completed some combined training with physiotherapists from the local NHS hospital and were looking into expanding this.

Multidisciplinary working

- Staff in the outpatient and imaging departments demonstrated multidisciplinary teamwork with informative handovers, good record keeping and good communication. Staff considered patients' individual needs during pre-admission discussions, which included the physiotherapists.
- The outpatient manager was looking at ways in which to improve communication between the outpatients department and the ward.
- A daily manpower meeting was held each morning with representatives from each department. Staff told us the daily meeting worked well and was often a forum to discuss incidents, issues and staffing for that day.
- The hospital had a service level agreement with the local NHS trust to transfer patients who required emergency treatment.
- The outpatients department had recently sent GP services letters to reiterate their admission criteria after an increase in unsuitable referrals and patients who did not meet the admission criteria.

Access to information

- All staff we spoke with said they had access to the hospital's policies, procedures, NICE and specialist guidance through the intranet.
- Important information such as safety alerts, audit results and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of current issues.

Good

Outpatients and diagnostic imaging

- The outpatients department reported no incidents where records were not available prior to a patient appointment.
- Discharge letters were sent to the patient's GP following completion of treatment. This ensured that the GP understood what procedures had been undertaken, and what follow-on care may be required. Care and discharge summaries were also given to patients on discharge.
- Staff reported timely access to test results and diagnostic imaging. This enabled prompt discussion with the patient on the findings and treatment plan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The outpatient and imaging departments were involved in obtaining informal verbal consent for such things as taking blood, observations and examinations. Consultants gained formal consent from patients for surgery during their initial outpatients' appointment. We saw evidence of consent form completion in patient records.
- Clinical staff groups completed consent training as part of their mandatory training. As of December 2016, 66% of outpatient staff and 60% of physiotherapy staff had completed this training (hospital target 100%).
- In the most recent consent audit (December 2016), the hospital gained consent correctly in 98% of cases.
- The hospital also had a mental capacity policy and a deprivation of liberty safeguards policy in place. The hospital used a dementia screening tool for all patients over 75 attending an outpatient appointment.
- Information about the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards was covered as part of staff mandatory safeguarding training. Records showed that 99% of staff had completed this training as of December 2016. Staff were aware of the policies and processes, but told us the majority of patients they treated had capacity to consent to their care.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

Compassionate care

- Staff treated patients with dignity and respect. We saw that consultation and clinic room doors were closed and curtains were pulled around during consultations to protect the privacy and dignity of patients. Staff knocked and sought permission before entering such areas.
- We observed all staff to be courteous, professional and kind when interacting with patients. We observed staff greet patients appropriately, and introduce themselves by name.
- Patient feedback was consistently positive. The patients and relatives we spoke with said that staff were 'all brilliant' 'impressive' and 'very helpful and professional'.
- The results of the Friends and Family Test (FFT) in June 2016 showed 97% of patients would be 'likely' or 'extremely likely' to recommend the hospital to their friends and family. FFT response rates were above the England average (75%, compared to 40%). In September 2016, 100% of patients surveyed said they were 'likely' or 'extremely likely' to recommend Horton Treatment Centre to Family and Friends.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. The hospital's PLACE score for privacy, dignity and well-being was 85%. This score was similar to the England average, 83%.
- There was a main reception area at the entrance to the hospital and an additional waiting area in each department. The outpatient waiting area was situated too close to the reception desk which meant patient conversations with reception staff could be overheard. However, reception staff were sensitive in conversations with patients and we did not observe any confidential information being discussed at the reception desk.

Good

Outpatients and diagnostic imaging

- Staff offered all patients a chaperone service during intimate personal care. Chaperone service information signs were clearly displayed in waiting areas and consultation rooms.

Understanding and involvement of patients and those close to them

- Staff in the department communicated with patients about their care and treatment in a way they could understand. Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment. Patients had sufficient time at their appointment to ask questions.
- Patients told us they were aware of the next steps in their treatment, and that follow up appointments were made quickly and within a reasonable timescale.
- Administration staff assisted patients to make follow up appointments. Patients were provided with a direct line to the outpatients booking administrator who would update patients on appointment changes and answer non-clinical patient questions.
- The physiotherapy department held pre-operation groups, giving patients the opportunity to ask staff questions before their operation.
- Leaflets, displayed in waiting areas, explained some of the procedures and diagnostic scans that were available. We saw a leaflet detailing the costs for self-pay diagnostic imaging services and further cost information could be found on the hospital's website.
- Safeguarding from abuse information was displayed where patients could see it.

Emotional support

- Staff showed a clear understanding of the importance of providing emotional support to patients. Patients described receiving emotional support from staff when they were anxious. For example one patient said 'the staff made me feel at ease the whole time' following a diagnostic imaging scan.
- Staff gave patients and their carers appropriate information to cope emotionally with their care, treatment or condition.
- There were sufficient numbers of nursing staff on duty to be able to provide additional emotional support to patients, if needed, without affecting delivery of the service.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

Service planning and delivery to meet the needs of local people

- The outpatient, imaging and physiotherapy departments all planned services around the needs and demands of local people. The hospital worked with the local Clinical Commissioning Groups and GP practices to improve patient access to services.
- The hospital participated in the NHS e-Referral Service. General practitioners from clinical commissioning groups referred patients to the hospital for a limited range of orthopaedic elective surgical procedures.
- The imaging department offered appointments Monday to Saturday, 8.30am to 5pm, to accommodate patients with commitments during the working week. Outpatient clinics were held Monday to Friday, 8.30am to 5.30pm, and alternate Saturdays. The physiotherapy department opened seven days a week but only offered a weekend service to inpatients.
- Patients were sent appropriate information prior to their first appointment, including appointment time, length and consultant name.
- The environment was appropriate for the services that were planned and delivered. The outpatient and imaging areas were bright and welcoming, with adequate seating and refreshments.
- The hospital was well signposted and had ample parking for patients. We also observed staff directing and assisting patients to the department they required.

Access and flow

- A senior nurse triaged GP referral letters to check patients met the strict admission criteria.

Good

Outpatients and diagnostic imaging

- Patients were offered a choice of appointments at times and days to fit their needs. The administrative and reception team managed outpatient appointments. The radiology and physiotherapy departments managed their own appointments and liaised with the ward clerk for inpatient follow-ups.
- It is expected that 90% of NHS patients will receive treatment within 18 weeks. From July 2015 to June 2016, 100% of patients were admitted for treatment within 18 weeks of referral.
- There were no patient waiting lists for radiology, outpatient or physiotherapy appointments, and the hospital actively monitored patient waiting times. This enabled trends to be identified and ensured services in high demand were managed appropriately to prevent patients care pathway delays.
- Patients entered the hospital via the main entrance and were registered at the main outpatient reception desk. Staff asked patients to wait in the correct department waiting area when arriving for their appointment.
- Clinics ran on time and we observed this during our inspection. Patients we spoke with said they did not experience long waits and many reported being taken straight through to their appointment on arrival at the hospital.
- For additional appointments patients could receive an x-ray investigation on the day of their appointment booking. For an ultrasound investigation patients may have to wait up to five weeks for an appointment. Patients received a letter to confirm their date and time whilst at the hospital.
- The hospital reported low 'did not attend' (DNA) rates. All patients who missed their appointment were telephoned by either the administration or nursing staff. From August to November 2016, the hospital reported 18 cancellations on the day of surgery. From reviewing data submitted to the CCGs, the majority of cancellations were due to the patient being unfit for surgery rather than the fault of the service. The outpatients staff were addressing this by reaching out to GPs and reiterating the admission criteria.

Meeting people's individual needs

- The hospital planned and delivered services to meet individual needs. Pre-assessment was used effectively to ensure the hospital only treated patients if they could meet their needs. We found that the service did not treat complex patients or those with multiple co-morbidity.
- Nursing staff recorded if a patient had additional needs during pre-assessment. Patients were given information leaflets about their planned procedure during their appointment or with their outpatient appointment letter. The patient information leaflets were written in English but were available on request in large print or another language.
- The ultrasound and magnetic resonance imaging (MRI) patient information leaflets were available in audio form, so that blind patients could listen to the information before their scan.
- The imaging reception desk had a hearing loop sign displayed for deaf patients. The desk also had a sign informing patients to enquire if they required any patient information in large print, translated or interpreted.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. In the assessment from February to June 2016, the hospital scored 91% for the suitability of the environment for a disability, better than the England average (81%).
- The outpatients and diagnostic imaging departments were both located on the ground floor and were accessible for patients with impaired mobility. Waiting areas and consultation rooms were all wheelchair accessible. Waiting area chairs were a mix of heights to help patients with mobility issues. The hospital also had accessible toilets and a lift if patients required access to the ward.
- A quiet room was available in the imaging department for staff to take patients who had received bad news.
- All patients over the age of 75 were screened for dementia during pre-assessment. The hospital's PLACE score, for the suitability of the environment for a patient living with dementia, was 96% (February to June 2016).

Good

Outpatients and diagnostic imaging

This was significantly higher than the England average (80%). The imaging department had a quiet room, which could be used to support patients living with dementia.

- For patients living with learning disabilities, staff involved carers and relatives in consultations. Patients could also attend the diagnostic department with family members prior to attending for investigations, so that they could become familiar with equipment and procedures.

Learning from complaints and concerns

- The hospital had a 'management of patient complaints' policy which provided staff with a clear process to investigate report and learn from complaints. Staff were aware of the complaints processes and had received customer service excellence training to assist staff when dealing with complaints from patients.
- The general manager had overall responsibility for all complaints, and would assign each complaint to the matron or relevant head of department for investigation. Each complaint was logged onto the hospital's electronic reporting system for tracking. Complainants received a response letter within 20 working days of their complaint. The hospital sent holding letters to inform patients if there was a delay in sending a formal response.
- The hospital received 21 formal complaints from January to August 2016. We reviewed three complaints that related to outpatients and diagnostics. The complaints were investigated and actioned in an appropriate and timely fashion.
- Patient's comments and complaints were listened to and acted upon. For example, the pre-admission investigation checklist was amended following a patient complaint after their surgery was cancelled.
- Patients who had complained were invited to join a patient participation group to attend meetings and give feedback on patient care. Despite advertising, the group was poorly attended.
- Complaints leaflets, describing the corporate complaints procedure, and complaints posters were available in both the outpatient and diagnostic departments. Patients told us they would be confident to raise concerns if necessary.
- There were procedures for sharing and learning from complaints across the hospital. Complaints were discussed at team meetings, heads of department meetings and the clinical governance meeting, and appeared in the staff newsletter.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

Leadership and culture of service

- We found that there were clear lines of management responsibility and accountability within the outpatients, radiology and physiotherapy departments. A visible, experienced and enthusiastic leader led each department. They were knowledgeable about their department and strived to continuously improve their service.
- Staff spoke positively about their heads of department and the senior management team. They described feeling valued and supported in their role.
- The senior management team promoted a 'no blame' culture and staff were encouraged to be open and honest about their concerns.
- Staff demonstrated mutual respect, regardless of profession. There was effective teamwork and professionalism in the way the organisation was managed.

Vision and strategy for this this core service

- The vision of the hospital was communicated annually to staff via the clinical strategy and hospital strategic business plan. There were numerous objectives set for the outpatients department, pre-assessment, radiology and physiotherapy for the financial year. Staff recognised their roles within the hospital strategy and were enthusiastic about changes and improvements.
- The senior management team were aware of the challenges faced by the different departments at the hospital, and there were plans of action in place to tackle those challenges. For example, the recruitment and retention of clinical staff.

Good

Outpatients and diagnostic imaging

- The Horton Treatment Centre had established a set of shared values for the hospital. The values focussed on ensuring high quality, safe care, minimising risk and promoting a culture of safety awareness.
- All staff we spoke with could describe the hospital values and demonstrated the values in the care that they delivered. Staff were proud of the service they delivered and consistently put the patient first.
- The physiotherapy department was looking to develop a standalone service which would take GP referrals directly.

Governance, risk management and quality measurement

- There was an effective governance framework in the hospital, which supported the delivery of good quality care in outpatients and the imaging department. The governance structure was supported by detailed policies and procedures for staff to follow.
- The heads of departments attended monthly meetings to discuss governance, quality reporting, incidents, complaints, audit results and key performance indicators. Trends were monitored and action plans were produced. Staff were provided with feedback and information about meetings in the form of minutes and in their team meetings.
- The matron led a clinical effectiveness and IPC committee which set monthly clinical objectives for all departments. For example, an objective for the outpatients department this year was to train specific staff for their plaster cast application competency so they could support the lower limb service.
- The medical advisory committee (MAC) was responsible for granting, reviewing and renewing consultants practising privileges.
- Each department had its own risk register and managers updated this accordingly. We reviewed the risk registers and found the risks identified reflected our inspection findings. Managers described the risk register as an effective way to escalate risks. Risks identified included theft of prescriptions and failure of mains power supply.
- The hospital had a combined risk assessment register which contained a list of all the risk assessments completed in each department.
- There was a full programme of audits across the hospital including within the outpatient, physiotherapy and diagnostic imaging departments. Although it was not always possible to identify audit data specifically for each department, the results of audits were discussed at clinical governance committees and any risks would be placed into the relevant risk register.
- A daily manpower meeting was held each morning with representatives from each department. The meeting focussed mainly on information about operational issues, but offered the opportunity for cross department information sharing.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by use of the patient satisfaction survey and for NHS patients by the Friends and Family Test. Results of the latest patient satisfaction survey (November 2016) showed 100% of patients reported excellent quality care. Results of the Friends and Family Test in June 2016 showed 97% of patients would recommend the service to their family and friends.
- The hospital was actively looking to recruit patients to join a patient participation group. The group met quarterly to discuss the patient experience but had been poorly attended in the past.
- There was evidence that the hospital acted upon patient feedback to help improve their service. For example, a patient fed back that the ward was too noisy and following this inpatients are now provided with ear plugs.
- The hospital also gathers and acts upon staff feedback through staff surveys and engagement committees. As a result of staff feedback, a non-clinical senior manager was appointed to give support to the senior management team and heads of department.
- There was hospital newsletter, distributed to all, to inform staff on departmental updates and patient feedback. There was also a 'you said, we did' section, detailing action the hospital has taken as a result of staff feedback.
- The outpatient and diagnostic departments had monthly team meetings in which staff were updated on new developments, clinical updates, staffing, changes in policy as well as sharing other information of interest.

Good

Outpatients and diagnostic imaging

- Staff were positively engaged with the hospital, and in their roles. One staff member told us they felt 'valued within the team' and another staff member described working in a 'supportive environment'.
- The senior management team organised team building days to improve communication between the senior managers and heads of department.

Innovation, improvement and sustainability

- The senior management team were responsive to requests and suggestions for improvement.
- The outpatients department had recently recruited a new staff nurse to lead on quality assurance and to improve the patient experience. Since their appointment, significant changes had been made within the department including an increased participation in the NHS Friends and Family Test and a reduced number of incorrect patient referrals, following contact with GPs. Their next project was to create an outpatient specific audit, to be completed alongside the hospital's annual auditing programme.
- The physiotherapy department were looking to create a 'one stop shop' for patients having hip or knee surgery.
- The care certificate was introduced for all healthcare assistants.
- The hospital ran a patient participation group, for patients to attend meetings and give feedback on patient care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the World Health Organisations five steps to safer surgery checklist is completed consistently.

Action the provider SHOULD take to improve

- The service should ensure that the environment does not compromise infection control practices in theatres.
- The provider should ensure that staff are aware of the acceptable temperature limits for the safe and appropriate storage of medicines.
- The provider should ensure that staff complete competency assessments before the application of plaster of Paris.
- The provider should ensure staff follow new standard operating procedures to manage medicines safely.
- The provider should ensure mandatory training completed elsewhere has been standard checked.
- The provider should ensure there is a clear audit trail on the use of prescription pads.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The regulation was not being met because: The World Health Organisations five steps to safer surgery checklist was not always completed consistently with patients undergoing local anaesthetic procedures.